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IT PAYS TO ADVERTISE

These are the three cardinal principles, so we are told, of good advertising: first, to indicate the product; then to attract attention to it; finally to get action.

It would be well to consider the cause of public health nursing in the light of these three principles. We wish to indicate the product, the public health nursing services, because of their value. We need to attract attention to these services because otherwise their usefulness will be limited. We hope to get action because we know that by so doing communities will be benefited.

How can these aims be achieved? All acknowledge the truth of the old adage that in union there is strength. Together we can accomplish many objectives that we could not by individual effort. True there are those who, intent on immediate, selfish aims, would leave all future progress to the natural course of events—whatever that phrase may mean—but most of us want to plan together with the hope that by unified endeavor we may reach our objectives.

We in public health nursing can achieve this union only through the National Organization for Public Health Nursing. This is the medium which has the authority to "indicate" our product —to tell what public health nursing is. Too, it is the vehicle which can "attract attention" as no individual or local organization could do. It is the unification of all our individual efforts which will "get action."

If we accept the hypothesis that by adhering to the principles of good advertising we further the cause of public health nursing, then it behooves us to lend strength to the National Organization for Public Health Nursing, and one of the simplest yet most effective ways in which we can give that strength and support is by individual membership in the National Organization for Public Health Nursing.

There never was a time when there was greater need of the work of public health nursing and the work of the National Organization for Public Health Nursing as there is at this time. These are troubled days in our social, political, and economic life and call for the most intelligent guidance that can be given. In a country such as ours, leadership is necessary and must be strengthened by public opinion and support. The National Organization for Public Health Nursing occupies a unique and important place in the social order of things, and its opportunities for service were never greater than they are at present. Evidence of this can be found in the increasing calls for help from individuals, communities, states, and even from the Federal Government.

The position of the National Organ-

ization for Public Health Nursing as a forum for discussion of important issues is a very gratifying one, and each year it increases its usefulness in this sphere. So we must not forget if the work of the National Organization for Public Health Nursing is to be carried on effectively that we must seize the opportunity of soliciting continued support and get the cordial coöperation of each individual interested in the cause of public health nursing that has been so important and valuable to us in the past.

It pays to advertise. If we really believe it, then let each one of us be part of the machinery which will set the wheels in motion to "indicate our product, attract attention to it, and get action."

SOPHIE C. NELSON, *Chairman*,
National Membership Committee

ILLNESS ON THE INCREASE

Dr. Livingston Farrand, a member of the N.O.P.H.N. Advisory Council, reviewed the health situation of the nation at the conference for the Mobilization for Human Needs held in Washington, D. C., September 28-29. He said in part:

"The need for extended health service is greater in these days of depression than it was during the years of prosperity. The death rates of the country have shown no striking increases. This is of course a welcome fact but it is not the one of first importance. The real question is as to whether lowered economic standards have brought about an increase in illness, at least to any degree which can be observed and measured. From trustworthy sources the evidence is now available that disabling sickness has shown measurable increase among those who have been most severely affected by lowered financial resources. A survey of great importance was conducted in 1933 (by the United States Public Health Service and the Milbank Memorial Fund) among 10,000 wage-earning families in 10 cities. The findings of that survey showed a high rate of disabling illness among those families hardest hit by the depression. The illness rate of the 'depression poor' was over fifty per cent higher than the rate which prevailed among their more fortunate neighbors of the same economic level who had suffered no loss of income during the depression. The direct relation of illness and unemployment is suggested by the fact that the sickness rate in families having unemployed workers was 66 per cent higher than the rate in families with full-time workers and 27 per cent higher than the rate in families with part-time wage earners only. These differences in illness rates appeared among the children as well as among the adults in the surveyed population. Notable, too, was the fact that the medical care received by families of the newly-made poor was little more than half that to which they had been accustomed in normal time, and one-half of the care they did receive was given free through the unselfish service of many physicians serving without remuneration."

"The world has had evidence enough of the far-reaching facts of malnutrition which is the inevitable accompaniment of poverty and privation when long continued. There are also certain specific disabilities which, while not yet subject to exact estimate, are causing well-founded disquiet in the existing conditions.

"An increase in nervous and mental disorders will be an inevitable consequence if the economic situation persists.

"The baffling scourge of syphilis shows an upward trend in its incidence rather than the reverse." . . .

"In short, the health picture of the nation justifies grave concern."

Medical Relationships
in
Non-Official Public Health Nursing Agencies

THE working partnership between the doctor and nurse has been throughout history one of the most productive and satisfactory relationships in the professional field and like all partnerships that have stood the test of time its success has been based on mutual need and mutual understanding. In illness, the doctor without the nurse to carry out his plans for the patient's recovery, is handicapped if not helpless, and the nurse without the doctor's diagnosis and orders is futile, but together it is possible to initiate and carry through steps that have a common goal—the patient's recovery. Mutual respect and complete absence of self-seeking characterize the ideal doctor-nurse partnership.

When graduate nurses first started working on a visit basis in the homes of the "sick poor," as these early patients were designated, a new situation arose. Nurses found themselves referred to ill people who had not called a doctor and who could not afford to call one. Fortunately, the pioneers in this work were women of foresight and high ideals. They at once laid down the rule which has been endorsed and followed by all succeeding public health nursing groups and is stressed in all the publications of the National Organization for Public Health Nursing—that nursing care is given to those who are sick only under the supervision of licensed physicians. Failure to secure medical authority for care after the first or second visit, brings to a close a nurse's ministrations which even during these preliminary visits are limited to "general care," carefully defined emergency measures and first aid—measures usually and advisedly approved by "standing orders" from the local medical authorities.

The development of preventive work in public health and the rapid rise of health education, both formal and informal, immediately presented more complicated situations. Should a public health nurse visit and continue to visit for purposes of instruction and convincing the parents of the need for action, a preschool child, apparently well, who has failed to be immunized against diphtheria, but is not under medical care? Should a nurse visit and continue to visit an apparently normal prenatal patient who refuses to see a doctor until the last minute? Will not her continued visits bring about the desired registration with a physician before the ninth month, will not one of her visits possibly reveal a serious symptom which will convince the patient of the need of care and possibly save both her own and the baby's life? If a mother is not taking her infant son to a clinic and is not under a private physician's care, should the nurse visit the mother regularly to give general instructions on infant routines and to keep track of the baby's weight with a view to insisting on a physician's care if conditions indicate?

MEDICAL ADVISORY COMMITTEES

To take care of these borderline cases in which it is so exceedingly difficult to decide whether a public health nurse is more teacher than nurse and which naturally give rise to misunderstanding and confusion among local doctors, the National Organization for Public Health Nursing has gone on record innumerable

*See *Manual of Public Health Nursing*, pages 72, 89, 91, 233; *Board Members' Manual*, pages 10, 73-78; *Principles and Practices in Public Health Nursing*, pages 15, 57; *Public Health Nursing in Industry*, pages 31, 108, 111; *Survey of Public Health Nursing*, pages 24-25, 102, 127, and other publications.

times as urging the use of a medical advisory committee* to which all questions involving new program, new developments in technique, new medical relationships of any kind and complaints can be referred for action. Preferably, this committee should represent the local medical society, but in any case it should be a group of physicians whose opinions carry weight in the community and who have prestige among their brother physicians.

In order to find out how medical relationships are now working among private public health nursing agencies, the N.O.P.H.N. in November, 1933, sent out a questionnaire to 160 representative public health nursing agencies in the United States. Replies were received from 132 and covered such points as use of the medical advisory committee, medical representation on the board, policies in relation to clinics and conferences, etc. The questionnaire was informal and urged the agencies to answer in full any point that had involved a problem.

In reporting on the answers to these questionnaires, we are not attempting to give detailed statistics but rather to summarize the general situation and offer suggestions toward better use of and coöperation with medical groups. Some of the suggestions come from the replies in the questionnaire, others result from the twenty-two years of experience of the N.O.P.H.N. and many—as our readers will realize—are reiterations of familiar policies that have been on the books since "district nursing" started.

SOURCES OF MEDICAL ADVICE

Of the 132 agencies reporting, 84 per cent have a regularly appointed medical advisory committee or a formal group acting in this capacity. Most frequently the size of this committee was three, with six the next most popular number; on about half, the health department was represented, the other members representing general and special practice, hospital boards, or the medical society. In 29 out of the 99 agencies with such committees the chairman of the medical advisory committee was a member of the board of directors of the visiting nurse association.

Appointment to the medical advisory committee was in 39 instances by the local medical society, in 36 by the board of directors of the agency, in several through combined action.

In the majority of agencies the medical advisory committee meets on call and many executive directors reported consulting the committee members individually as occasion arose rather than attempting to call them together. In three agencies the committee meets with the board. There was, however, great irregularity in the formal meeting of this committee; one agency reports no meeting for over a year, another feels satisfaction with a plan to meet every three months. As a rule some member of the board and the executive director meet with the medical advisory committee. However, here too great variation exists as to who represents the board—the president, vice-president, chairman of nursing committee, all of the executive committee, etc. Three agencies report no representation of board or staff at the meetings of this committee.

Of the problems presented to the medical advisory committee the following are typical and the number of agencies mentioning them follows:

Approval of standing orders	62
Discussion and approval of new procedures	41
Approval of nursing techniques	37
Discussion of medical problems and complaints	18
Relationships to profession at large	5
Work of the organization as a whole or some particular phase, such as clinics	4
Public health and nursing matters in the community	1
Health examinations of the staff	2

Agencies were asked if physicians were members of the board: 61 of the 132 replied yes, 71 no; 11 boards include the local health officer, 6 a representative of the medical society, the other physicians being chosen at large for their interest and help and not by virtue of their official connections. Forty-three agencies felt that physicians on the board were useful, 14 were not in favor of them, while 75 agencies expressed no opinion on the question.

Some of the drawbacks listed to having physicians on the board were:

Their scope is restricted, as members of the board.
Disadvantageous to show favoritism to one or two doctors in a small community.
Small influence on medical group as a whole, little interpretation of nursing service resulting from their presence.
Impossible to give fair representation to medical group through only one or two board members.
Medical problems too big to be considered by one or two doctors who might or might not report to the medical society.

Three-quarters of the agencies replying, however, stated that they considered a physician on the board helpful whether they had one or not!

From among the comments on the relationship with physicians through advisory committees and board representation we quote a few examples of procedures sent us by those agencies which feel they have interpreted their program successfully to the local medical group.

(1) "We use the medical advisory committee or a subcommittee of it continuously and intensively when we start a new phase of our work. The psychiatrist, for instance, when we started mental hygiene work, was chairman of a committee that met once a month for two years."
(2) "Our medical advisory committee has full charge of medical problems and policies relating to our baby conferences. This committee meets alone."
(3) "All our medical problems are referred to the public health nursing and child welfare committee of the county medical society. This committee meets monthly."
(4) "A complimentary luncheon is given once a year to the medical advisory committee. This makes for friendliness."
(5) "Our medical advisory committee meets with a committee of three appointed by the local medical society. All medical problems are handled in this joint fashion." [This would seem to be a very excellent plan.—The Editors.]
(6) "We feel we have been too casual about our committee. We are planning regular meetings and a series of problems for discussion this year."
(7) "On initiation of new program, members of committee especially interested offered to present the subject matter to and work out procedures with our staff."
(8) "Our committee arranged to have our executive director speak to the medical staffs of every hospital in the city."

It seems to be the general opinion of the agencies that the present functioning of their medical advisory committee is satisfactory; in some instances this statement is qualified by, "in so far as the committee now functions." Some of the reasons given for the unsatisfactory functioning of this committee are: lack of knowledge of the work; lack of interest on the part of members of the committee; lack of knowledge of public health nursing; no change in members for a number of years, and difficulty in getting members to attend meetings.

The foregoing facts about the medical advisory committee raises the question as to what is the function of this committee. If it is merely a group to be consulted when particular problems arise and is not concerned or interested in the general work of the agency, it might be considered that its present usual set-up and functioning are fairly satisfactory. If, however, it has a broader function, the present plan of irregular meetings, lack of knowledge of the work of the agency, and concern only for the question brought to its attention would seem to indicate that this committee is not functioning to fullest capacity. Also it would be of interest to know how the 16 per cent of the agencies who do not have medical advisory committees settle their medical problems and how completely the local medical groups understand the nurses' service.

The *Survey of Public Health Nursing** (page 102) indicates an even larger percentage of the non-official agencies studied who do not have medical advisory committees: 10 out of 21, almost 50 per cent.

By whatever method the board of directors or those responsible for official public health nursing agencies choose to relate the work to the medical group, the *Survey* states that it is clear "that any nursing service must have medical advice either from within or from without the agency administering the service. Furthermore, the nurse *must* have medical authority for any procedures involving treatment. It would be desirable for the local medical society to be informed of the nursing procedures of any public health nursing service by

*The Commonwealth Fund, 41 East 57th Street, New York, $2.00.

whatever agency administered and that these in general be acceptable to the local medical profession."*

SPECIAL PROBLEMS

Several questions were asked the agencies concerning their procedure in cases where patients had not called a physician and among agencies in which a health education program was being carried, their procedure with individuals who were not, at the start, under a physician's or clinic's supervision.

Of the 132 agencies, 106 have "standing orders" approved by the medical group—96 allow two visits by the nurse without a physician in charge (others, one visit with care, one without); two agencies in large cities do not limit the number of visits the nurse may make without a physician in charge, and 23 allow an indefinite number on prenatal cases only. Nursing care is of course limited to procedures defined by the standing orders.

All the agencies carrying on a health education program expect their patients to arrange for medical supervision at a clinic or with a private physician, but there seems to be wide variation in practice as to continuing to visit for educational purposes.

When a patient who can afford to call a physician for illness has not done so, and has no family physician, 70 agencies give a list of physicians to the patient from which to choose one, 29 leave it entirely up to the patient and family, 11 refer to the local medical society, and 4 refer to a local hospital.

Among patients unable to afford a private physician for illness and having no regular doctor, 72 agencies refer to city, county, or township physician, 17 to the welfare department or organized relief agency, 3 have a list of physicians who have volunteered free care, and in one agency the nurse assumes the responsibility for calling the physician.

ELIGIBILITY TO CLINIC REGISTRATION

A problem of considerable interest to agencies carrying the responsibility of conferences and clinics is that of eligibility of patients for clinic service. Sixty-four agencies carrying on clinics or conferences reported on this problem. Eleven have no restrictions, four a residence requirement, 49 report that patient is admitted if "unable to pay physician." Several of these latter agencies make an attempt to state a definite maximum income limit for eligibility. These allowances are:

Family with one child, $85 a month; two children, $95 a month; three or more, $125 a month.

Family with one child, $90 a month and $10 allowance for each additional child.

Family with one child, $95 a month, maximum income $100 a month.

Family with one child, $25 or less a week. Three children or more, $30 or less a week.

Family with one child, $110 a month; $10 a month for each additional child.

Family with one child, $75 a month—no charge for clinic service; $75-100 a month—25 cents a month; $100-125 a month—25 cents per clinic visit; over $125 a month—discharge to private physician. $15 a month is allowed in this last scale for each additional member of family.

In prenatal clinics with a physician in attendance, 8 out of 25 agencies reporting, state that patients not registered with their family physicians or for hospital delivery are not carried. In agencies with prenatal conferences *without* a physician in charge, twelve carry patients not registered with a doctor or hospital. In one of these cases the local obstetricians have agreed to this practice—feeling that the mothers' classes are educational and the normal prenatal patient is not ill. In the other agencies the rules vary greatly.

Physicians serving at clinics are usually chosen—these reports show—by the agency itself through its board and medical advisory committee, if there is one. The local medical society appointed the clinic personnel in ten instances only. Most agencies pay the physician a nominal fee for his service—the average rate being $4 per session.

The *Handbook on Records and Statistics in the Field of Public Health Nursing* defines clinics and health conferences as follows:

**Survey*, p. 25.

"Clinics and health conferences are meetings arranged for a definite time and place, for the examination, inspection, or treatment of cases and the individual discussion of health problems or disease conditions. Service is to an individual and necessitates individual case records.

"Clinics are usually for sick persons and are always in charge of a physician.

"Health conferences are usually for healthy persons and may be either medical or nursing, depending on whether a physician or a nurse is in charge.*

It is evident that health conferences, frequently still termed clinics** by public health nursing agencies, are used widely by community nursing services and not infrequently are administered by them, although the N.O.P.H.N. *Board Members' Manual* recommends that:

"The best present day practice suggests that it is better for public health nursing associations not to be responsible for maintaining clinics and dispensaries. It may be desirable to do so (with the approval of the medical advisory committee) for a demonstration or as a temporary experiment. In the long run, however, it is sounder policy for the health officer, or a hospital or some other medical authority to be responsible for the actual provision, and supervision of medical services. The best results will usually follow when the public health nursing organization gives or sells its nursing service to clinics operated by such medical bodies.

"If the public health nursing organization does operate clinics, or conferences, it is better for the board or committee not to pay the physicians directly for attendance at the clinics, etc., but to pay a hospital or the health department for the services of certain physicians who shall be assigned by them to the different clinics or child health conferences. The advantage of this is that punctuality, absenteeism, and sometimes even the question of the type and caliber of medical service given is dealt with by some medical supervisor and not by the nursing staff or board or committee of the nursing organization."***

ADMINISTRATIVE SAFEGUARDS

The experience of the last ten years during which there has been a constantly increasing number of clinics, health conferences and classes, has shown that there are certain safeguards to be observed in assisting in the conduct of such services. These safeguards make it possible to avoid misunderstanding of the clinic's function, in the minds of the general public, define for their own use the extent of responsibility of the clinic doctor and nurse and their relation to patients outside of clinic hours, as well as their relation to other doctors and health agencies in the community. Some of these safeguards are listed here for the benefit of those agencies that are conducting or connected with this type of community medical and nursing service:

(1) On organizing, the need for the health conference should be generally evident and statistically proved.

(2) A committee representing the medical profession, agency board and staff and other interested groups should consider the idea from all angles and discuss it with other social groups, if possible through the Council of Social Agencies. The consent and suggestions of the authorized health authorities should be obtained by the committee in charge of the plan and recognition secured from the local medical society. Methods of promoting the service and possible inter-relationships with other agencies should be studied and discussed before starting.

(3) The purpose of the health conference should be clearly defined and strictly adhered to.

(4) When a conference is established by a private nursing agency, the medical service should be secured through the recognized local medical society or health department. The nursing agency is responsible for conducting the conference and equipping it according to accepted standards and the physician's wishes.

[At this particular time, with so much activity in the relief field and the need for medical and nursing service so evident, it would not seem a propitious moment for public health nursing agencies to take the initiative in the organization of new clinics and conferences at which medical service is offered. In the past the desire to demonstrate the need or to experiment with new services frequently led public health nursing agencies to establish conferences. This would not seem wise at present. The responsibility for the organization for such clinics and conferences should rest with the medical professional groups, the public health nursing agencies standing ready to offer nursing services.

These remarks would not affect the carrying on of health classes conducted by the nursing staff at which instruction only is given.—The Editors.]

(5) The physician in attendance should be paid for his service. The amount may be agreed upon when submitting the initial plan to the medical authorities, or may be arrived at in arranging with the group which is to supply the clinic physician. The supply and payment of clinic medical service should not

*Government Printing Office, Washington, D. C. 5 cents.
**Technically the term clinic should be used only when a physician is in attendance.
***See also *N.O.P.H.N. Public Health Nursing Manual*, pp. 106-107, 144.

come—preferably—from a nursing organization.

(6) It is customary to limit medication prescribed by the conference physician. Mineral oil, cod-liver oil, and local ointments are usually permitted. A small fee for this service to patients may be asked if warranted by local circumstances and approved by the medical group.

(7) Patients able to pay a private physician for care should not be admitted to conferences at which physicians' services are offered unless some arrangement has been approved by the medical society. Patients unable to pay a physician may be admitted if this policy meets with the approval of the local medical group.*

Health conferences or classes with no physician in attendance are usually not limited to any one income group, but when medical orders are carried out or patients under a doctor's care come for additional instruction, the rule regarding permission from the private physician should be observed.

(8) If the patient has no connection with a private physician whose opinion can be sought, the nurse will have to decide on the eligibility of a patient for service on the basis of the patient's own statement, her knowledge of the community, and the conference physician's impressions. Later home visits should make it possible for her to verify her decision.

(9) Young children unaccompanied by an adult should not be admitted to conferences, except in the case of school health services, when the presence of the parents should be strongly urged.

(10) The question of whether physicians should accept home calls from conference patients in case of illness during their terms of service should be left to the local medical society to decide.

PLANNING FOR BETTER RELATIONSHIPS

From all the replies received to our questions regarding working relationship with the medical profession, certain points stand out:

It is entirely evident, and recognized again and again in the "remarks" on the questionnaire, that agencies have not given enough thought to planning ways and means of interpreting their objectives to private physicians or of using the local or county medical society effectively. Complaints from physicians—which we are glad to report seem encouragingly few—arise in nearly every instance from any one of these causes:

(*a*) Misunderstanding of the public health nurse's function in the home.

(*b*) Seeming disregard on the part of individual nurses of the fundamental ethical principle of rendering nursing care at home or in conferences *only* on the authority of a physician (standing orders or individual order).

(*c*) Poor handling of clinic organization with failure to enlist the coöperation of the organized medical group.

(*d*) Apprehension on the part of the physician that the nurse is taking his practice or asking him to give free care to those able to pay, or that she is referring to free clinics those who have been his patients and might pay eventually if not now.

(*e*) Familiar difficulties which every association should tackle and settle through frank discussions with the local medical society, such as: physicians wishing the nurse to remain with patients throughout labor; requesting that the nurses do not do urinalysis or take blood pressure of prenatal patients; requesting to have the nurses do night duty, visit the patient at the same time every day, or have the same nurse every day, etc.

CONCRETE SUGGESTIONS

What are some of the steps** agencies have taken to improve these relations?

(1) Personal calls on all the physicians by the director of the service or by supervisors or staff nurses within their own districts.

(2) Immediate personal conference with the physician in case of any complaint, misunderstanding or problem—sometimes both staff nurse and director confer with the physician, sometimes the director only.

(3) Continual reporting to medical group through letters, annual reports, etc.

(4) Physicians invited to visit headquarters and attend annual meeting.

(5) Arrangements made to have director speak annually at the medical society meetings.

(6) "Council of Social Agencies held many meetings with private and public physicians, resulted in closer coöperation of public clinics, private physicians, through reference first to private physician before admitting to clinic."

(7) County medical society providing volunteer doctors to whom border line cases are referred, instead of referring to city physician or private clinics.

(8) "We are more and more going to the physicians *without* any problem—frankly to ask their advice as to how satisfactory the service is and what suggestions they have for improving the service. We occasionally get rather helpful ones. Most of all, I think this gives them an opportunity to say everything they want to and gives the supervisor and nurse an opportunity to explain further our service."

(9) "We have been more scrupulous in keeping in touch with physicians for orders throughout the course of the patient's illness

*See PUBLIC HEALTH NURSING, January, 1933, Cleveland's plan.

**In addition to the suggestions already made by the N.O.P.H.N. in the *Board Members' Manual* (pages 73-78) and other publications.

and in sending them reports of prenatal visits. The nurses have formed the habit of calling at their offices or talking with them quite freely over the telephone, and a supervisor has gone with the nurse to see the physician whenever there has been a complaint or a misunderstanding."

Miss Gardner writes: "Public Health Nursing has had in the medical profession one of its greatest friends and also not infrequently one of its greatest stumbling blocks and this seems to have been the case everywhere . . . . Such codes as that governing the relation of medical and nursing professions are the result of a slow accumulation of experience and tradition. In taking new steps an orderly sequence should prevail."*

We were aware that many of the apparent stumbling blocks in our relationship with the medical profession were of our own making—sins of omission rather than commission. This brief survey of situations strengthens this conviction and drives home the realization that we have not interpreted well, nor taken time to explain, nor sought understanding and coöperation before proceeding. We have seen failure and success and we have learned from experience what should be done. It remains for each local agency to seek medical advice and to plan on a mutually satisfactory working relationship for the future.

*_Public Health Nursing_. Mary S. Gardner. The Macmillan Co. $3.00. pp. 43-44.

The Physician and the Visiting Nurse Association *

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PERHAPS no topic has been more frequently discussed before nursing organizations than their medical relationships, and there is probably nothing new to be contributed at this time. On the other hand, a wide contact with nursing problems on the part of the speaker does, at any rate, lead to certain impressions as to the relative significance of the factors involved in the very important relationship between the doctor and the nursing organization, and an observation or two may not be altogether untimely. We have in mind particularly the private medical practitioner, and especially the general family physician, rather than the specialist, the clinic worker, or the health official, although the latter individuals have peculiar problems of their own which to some extent overlap the general medical relationships.

Among the several basic considerations, perhaps the one most frequently emphasized is the fact that in theory as well as in practice the physician and the nurse constitute a team, that can work well only with understanding on both sides of the partnership. They have a common objective, so far as actual bedside care is concerned, and that is to serve the patient. The doctor assumes the primary obligation, namely, to restore the patient to health, and often, in order to do this most promptly and completely, it is necessary for him to farm out part of his job, either to the nurse, or the hospital, or the specialist, or to other agencies. In this relationship there appears to be no basic difference, whether the nurse is giving bedside care exclusively, or whether she is, in addition, a public health educational nurse, except that, if she is the latter, her own obligations are broadened to include more concretely the teaching of home care, the control of contagion, the teaching of home hygiene and of public

*Presented before the Westchester County Council of Social Agencies' institute for public health nursing organizations, White Plains, N. Y., October, 1934.

sanitation. These broader obligations she shares with the doctor, but she is expected to execute them on a basis of a more organized relationship with community facilities. Nevertheless, the doctor and the nurse are still a team, with, respectively, a major and a supplementary yet coördinated obligation toward the patient. While both have various group and community responsibilities in addition, yet this primary relationship should never be lost sight of.

Now, somewhat in contrast to this picture, it has been claimed that there is an essential conflict between the doctor and the nurse. The doctor is an individual. On the average, he earns a precarious living dependent mainly upon illness in his community. His primary interest is the curing of sick people. On the other hand, the nurse is a member of an organized group. She has a salary fairly independent of the incidence of illness in the community. If a public health nurse, she has been trained in the point of view of prevention and she frequently looks upon that as her primary purpose in living. There is a distinction here. Yet, the distinction is not a clear-cut one. The doctor is also interested in prevention and has contributed much in this field. There is fortunately a growing preventive element in his practice. At the same time, most nurses in their routine are still required to do some therapeutic work. And, incidentally, from the angle of the private practitioner, it would seem to be advantageous to have this always the case. The doctor knows the nurse who works with patients. He is much more interested in her if she does some actual nursing. That's more in his line. He is apt to fail to understand and consequently to underrate the "talking nurse."

Of course, in the whole field of public and private medicine, prevention and treatment inevitably overlap in any case. They cannot be clearly separated. Look, for instance, at the fields of venereal disease control and of communicable disease in general, where cure is often in part prevention, or the reverse.

OF MUTUAL HELPFULNESS

Is there, then, a real conflict on this score? At the present time there certainly are circumstances that lead to misunderstandings and to divergencies in approach and emphasis. But if in our visiting nursing work we sufficiently impress upon the doctor the concrete serviceable things that the nurse can and does do, the private physician will be inclined to see the nurse in a more favorable light. If, at the same time, the nurse is aware of the growing opportunities for the doctor in preventive medicine, and if she helps to promote the use of the private practitioner's preventive medical services, she can not only improve her relationships with the doctor, but can aid in the opening up of a very important field of medicine. She should bear in mind the kind of preventive things that the doctor can do for the patient and for the family. By advice and guidance she can advocate health examinations. She can encourage early diagnosis of incipient disease. She can promote immunizations, especially among patients who are able to pay private fees for such services. She can keep in mind always the advantages of prenatal medical service, of occupational guidance, of preschool examinations and defect corrections, etc. Thus may this conflict be eliminated by the removal of the distinctions which now support its existence.

DO THE DOCTORS KNOW YOU?

These are some of the things that the individual nurse should keep in mind in furthering private preventive medical practice and in merging her preventive interests with those of the doctor. We mentioned above the importance of having the doctor realize that the nurse not only educates but serves. We implied that the doctor needed education in this regard. He knows the nurse, but not the public health nurse.

In our own organization we have recently been impressed by this fact. In coöperation with health departments, visiting nurse associations, and medical societies, we have been endeavoring, through an educational campaign, to

decrease our pneumonia mortality by increasing, in several of our larger cities, the percentage of our policyholders eligible for nursing service that get this nursing care. We have approached the physicians and urged them to call for the nurse. We have even agreed to share visiting nurse associations' costs should these calls become excessive. Thus far little progress has been made, primarily because the rank and file of physicians in our larger cities, with excellent nursing organizations, know little about the nursing organizations, are scarcely aware of the existence of the nurses, don't know what they do or what they are supposed to do, do not know how to call them, and have an attitude toward them based on ignorance, or suspicion and distrust. That handicap must be removed before we can get these doctors to call nurses for cases of pneumonia, for cases of communicable disease, for cases in families where the patients are able to pay a reasonable fee, for cases eligible through an insurance relationship or otherwise.

We have recently suggested to a number of visiting nurse associations that here is an obligation apparently unrecognized and an opportunity going to waste. We have suggested that one of the best approaches would be to tackle this problem of medical interest and orientation on the basis of pneumonia and communicable disease control. Here there is a volume of need for nursing care, which should be of greater value in pneumonia, for instance, than in any other acute disease. The nursing and educational possibilities in the communicable disease field are inexhaustible, and there would be found here a generous supply of non-clinic type, non-indigent, paying patients.

DOES HE KNOW WHAT YOU CAN DO FOR HIM?

This is all a part of selling the doctor the nurse's services. Few doctors have a very complete appreciation of what the nurse can do for him, his patient, and the patient's family, such as the giving of instruction to the mother concerning the baby's formula; the giving of instruction in, and the oversight of quarantine and isolation, if the health department is willing to have the private association nurse serve in this capacity; the taking of diphtheria swabs for release; the collection of sputum specimens; the offering of urinalysis and blood pressure services for prenatal patients; the administration of insulin and the giving of family instruction in this regard—all, obviously, under the doctor's specific direction and all, of course, on a basis of her direct reporting back to him.

INITIATIVE FROM THE NURSING AGENCY

If these kernels of conflict are to be eliminated and if these gaps are to be filled, the initiative must be taken by the visiting nurse association, either independently, or in coöperation with the medical societies. The doctor is an individual. His training largely immunizes him against organization consciousness. His main contact is an individual relationship. But the visiting nurse association is an organization. It recognizes public health obligations. It is anxious to serve people when they are sick and to help keep them well when they are well. Yet when they are sick they are patients of doctors and when they are well they should have the advantage of preventive medical surveillance. Consequently, if the nursing organization is going to apply its services to the full, it has to sell those services to the doctor. True, it must also educate the public, with the coöperation of health departments, medical societies, and social agencies. But the two things, namely, the education of the public and the informing of the doctors, must go hand in hand, and it is largely a visiting nurse association job.

GUARDING AGAINST MISTAKES

To touch for a moment on a matter of less importance, there are some things that some nurses have done in the past that doctors have not liked—things that are contrary to medical ethics and also to nursing ethics. They need scarcely be mentioned here, although they are always to be guarded against. Frequently they constitute errors in judg-

ment, or over-enthusiastic indiscretions, that perhaps have been more frequent in the past than in the present, but that have created suspicion and a shyness on the part of the doctor which time and good performance are overcoming. We have in mind such simple errors as the making of diagnoses; the prescribing and administration of therapeutic measures beyond the medically approved standing orders; the contradicting of medical advice; the playing of medical favorites; the referring of patients to specific physicians; the recommending of a change in physicians, etc. We must all admit that circumstances often tempt intelligent and sympathetic nurses to these mistakes in judgment, and sometimes, in individual cases, seem to justify action along these lines. Nevertheless, the ultimate good of medicine, of nursing, of public health, and of the interrelations of all of these elements is better served by adherence to a rigid, but, after all, slowly evolving ethical practice.

Basically, the nurse has a primary job and that is the supporting and upholding of the private family physician, so long as private medical practice endures on its present relatively unsocialized plane. She should not over-exploit the specialist on the one hand, nor place undue emphasis upon free clinical services on the other. She should not, of course, ignore her community obligations. But it is a rare circumstance indeed where tact and judgment will not remove a conflict between these obligations and her loyalty to the physician in charge of the case.

There is one other distinction which others have touched upon and which might be mentioned here. The doctor is apt to think of disease in two general classes: communicable and non-communicable. He recognizes that, so far as communicable disease is concerned, prevention is essential, collective action necessary, and the attitude of the community vital. He can readily see that the public health nurse, either representing an official or a private agency, would be apt to have a definite community obligation in regard to such disease, just as is true of himself in cases of this type. On the other hand, he also recognizes a large field of non-communicable disease—heart disease, nephritis, diabetes, etc., where treatment is the primary consideration, where prevention is mostly a matter of personal hygiene and education rather than community action, and where, above all, the preservation of the personal relationship between the doctor and the patient is of paramount importance. I think even here the average physician can be led to see that the public health nurse may serve very helpfully, but the relationship is on a basis differing from that which prevails in communicable disease control and is relatively limited. In any event, while the doctor can readily see the nurse's job in the public aspects of communicable disease control, and while he will probably to a greater and greater extent welcome the private visiting nurse into the field of treatment and individual guidance in these non-infectious and degenerative cases, he has still largely to be informed and convinced concerning the educational and supplementary services which the nurse can render to him and his patient in this latter situation. Here again the opportunity and the initiative lie with the organized community agencies, and it is not likely that health departments, medical societies, and social and educational agencies will take aggressive measures aimed at a broader knowledge of nursing facilities on the part of the doctor and a greater utilization of those facilities unless leadership and vision in each community are furnished by the visiting nurse association.

IN SUMMARY

In summary, it comes down to this:

1. Let us recognize the essential "team" relationship between the doctor and the visiting or public health nurse, each with a primary obligation to the patient, and with supplementary community obligations as well.

2. Let us try to resolve the actual or potential conflict between the private doctor and the treatment motive on the one hand, and the public health nurse and prevention on the other, by:

a. Retaining at least a minimum of the genuine personal service element in the field program of the nurse—a phase of her work which the doctor automatically understands and appreciates.

b. Utilizing the help of the nurse to expand for the doctor the growing field for the private practice of preventive medicine.

c. More fully informing the doctor as to the wide range of concrete services the nurse has to offer to him and his patient, in both treatment and prevention, perhaps using pneumonia and the communicable diseases as fresh wedges in more widely opening this field, particularly as it encompasses the non-indigent patient.

3. Let us avoid the errors of the past, recognizing the basic obligation of the nurse to uphold the procedures and standards of private medical practice, and to aid in preserving the personal relationship of doctor and patient.

4. Let us recognize the at least contemporary distinction in the doctor's mind between communicable diseases with their community and epidemiological relationships on the one hand, and the non-communicable, constitutional affections, with their essentially private features, on the other.

5. And finally, let us call upon our visiting nurse associations to furnish, in coöperation with other community agencies, the vision and leadership essential, first, to the acquainting of the doctor with the character and purpose of the visiting nurse association and the public health nurse; to the "selling" of the nurse's wide range of services to the doctor; to the wiping out of existing points of irritation and conflict; to the featuring of the doctor's and the nurse's common interests and objectives in both treatment and prevention as they affect the patient and the community.

A successful window exhibit, Visiting Nurse Association, Wilmington, Delaware

How to Improve the Teaching Content of a Public Health Nursing Visit *

By LEAH M. BLAISDELL, R.N.
Extension Secretary, Division of Public Health Nursing, New York State Department of Health

LIKE the proverbial drops of water and grains of sand, nursing visits are undeniably the units of the great whole of health work, and the entire service will be just as strong as its individual units. They are therefore, the most vital problem in our work.

Now if we are really convinced that a complete health service includes not only the prevention of illness and correction of defects, but also the promotion of positive exuberant health as the right of *every* individual of *every* community, we shall realize what a huge task is still before us. This is what the public is increasingly demanding of us. At present we are short of trained public health nursing power all over the country. That makes it supremely important that every visit be used to the very best advantage if we are to make any impression on our task. A further factor which should influence us in seeing that visit content is of high order is our moral obligation to those who furnish the funds. Whether private or official they are trust funds collected with difficulty and entrusted to us for the definite purpose of improving the community's health, and we should see that they bring results.

What will improve the teaching content of a nursing visit? This is not a new problem. It is one we have been tussling with for the past twenty years. Visits have been analyzed and many useful principles have been evolved with which most of us are quite familiar. Some of the most important of these are embodied in the interesting series of visit outlines, worked out by the Scranton (Pa.) Visiting Nursing Association, published in the March and April numbers of PUBLIC HEALTH NURSING.

The Scranton staff has emphasized:

The friendly approach.

A definite plan of what should be taught during the period of contact with the family and a decision as to just how much or how little to teach at each visit.

Adoption of the teaching content to the individual situation which the nurse finds in the home.

The value of actual nursing care or demonstration with explanation of every procedure and teaching it to someone in the family.

The value of having the family assume its own responsibility as rapidly as possible.

Consideration in every visit of the total family health situation rather than just the prob'em of the case being carried.

The wise use of records in providing continuity.

The value of positive teaching—commendation for the good rather than condemnation for the poor.

Use of personal written instructions.

Use of literature.

Planned repetition of teaching and follow-up to see that it is put into practice.

I admit inability materially to improve upon these points and think we would all agree that we could feel very serene about the future in public health if all public health nurses were making the type of visits these plans suggest!

MAKE IT YOUR OWN

As I see it, we are now at the point where we must search deeper than improvement in techniques. We must study how better to get them used by all nurses. I believe the Scranton staff has pointed the way in what I consider the most important part of this contribution—the fact that the *staff members participated in working out these plans*. Drawing, evidently, from a rich

*Presented at the N.O.P.H.N. Round Table for Supervisors and Educational Directors, Biennial Convention, Washington, D. C., April 24, 1934.

background of scientific information regarding the maternity problem and educational methods, they sorted out the essential knowledge and as a group project arranged it in a practical manner for teaching. No other organization that takes its plans verbatim and thrusts them upon its staff as accepted procedures will derive the value from them that the Scranton staff has. We may borrow suggestions about technique from other people, but only by working them out and arriving at conclusions which "may be poor but *me own*" do we treasure and use them wholeheartedly. Overlooking this fact is, I believe, one of the criticisms that may be offered regarding much of our public health nursing in the past. We have taught nurses techniques rather than the problems and principles from which they can conclude no other than the best techniques and from which they can see the importance of preparing themselves for doing a growing and progressively better job.

If this is a criticism, may it not also be a clue as to how to improve the teaching content of nursing visits in the future? Is there any reason why we cannot all change our teaching emphasis from techniques to principles and then build up *with* our nurses plans for their intelligent application to our health problems? Undoubtedly you will all agree that nurses so prepared would be better health teachers, but probably some of you are thinking that it is impractical, that it would take too long to prepare nurses this way and that many nurses are not thinkers anyway.

IMPROVING THE SUPPLY

I accept these challenges for the moment but ask you to take a long-time point of view with me. Do we not seriously believe that public health nursing is a profession of sufficient importance that we should view such challenges with alarm? If we do not have nurses who can do this sort of thinking, had we not better find out why and correct the cause? Is the cause that of poor selection of students in our schools of nursing? Are we admitting young women without a sufficiently high grade of intelligence? Are they being educated to follow orders blindly rather than to think? Does it take too long to prepare nurses on our staffs because they have not acquired the basic scientific knowledge and health viewpoint in the nursing school?

Don't think this is not our responsibility! If we, as educational directors and supervisors, cannot put our finger on our troubles and demand their correction, we shall have only ourselves to blame. We certainly cannot expect institutional people to seek them out and correct them for us. Studies recently made in New York State show rather conclusively that nurses are being educated for institutional work, but are failing to get preparation for community problems. A slight idea of this situation will be realized from the following: Of all the nurses who sought licensing examinations in New York in 1931, only 13% had had any experience in communicable disease nursing and this includes those who had had as little as 5 days; only 15% had had any psychiatry, and that included as little as 6 days. Only 9% were experienced at all in tuberculosis nursing and these were considered experienced if as little as one week's time had been given to it, and only 6% had had any public health work, even when so much as one day was considered. I do not need to mention how rare it is to find that any instruction or practice is given in how to teach, yet a public health nurse is a teacher every minute she is in service.

HOW CAN WE HELP THE SITUATION

It is true that institutional people are thinking in terms of prevention of illness more now than formerly, but that conception of public health leaves them about ten years behind. Positive health work is the keynote today. Considerable recent experience convinces me that we have been successful in only rare instances in getting that newer point of view implanted in our schools of nursing. Obviously it would be unfair to project our difficulties on schools of nursing without doing anything to help correct the situation. How many of us are active members in the National League of Nursing Education and work-

ing through that organization to see that this basic training is improved? What can we do?

First, we can lend our influence in raising standards for better selection of young women in schools of nursing.

Second, we can explain and demonstrate what we mean by positive health to school faculties and supervisors. If you should come to Albany next week you could attend an institute conducted by the Hudson Valley League of Nursing Education. The sessions of one whole day are to be devoted to public health educators. An idea of the importance and possibilities of health teaching will be given the several hundred institutional people attending through papers, general discussion and a three-act play showing prenatal and postpartum visits in which will be embodied all of the positive health teaching possible. More of this kind of influence is needed if our schools are to become health minded.

Third, we can encourage the placement of a public health nurse educator on the faculty of every school of nursing, who will work with the faculty and supervisory staff, as well as the students in getting a health point of view.

There is continual improvement in this situation and a few schools are doing an excellent job. I have in mind the Mary McClellan School of Nursing in Eastern New York. It is attached to Skidmore College where the prospective nurses spend the first year in study of the sciences. A careful study and selection of the nursing students can be made during that length of time. Then they are introduced to the hospital. It is in a rural area and has a public health nurse on its faculty who correlates all of the hospital activities and patients with the community situation. For example, a prenatal case is assigned to the student nurse. She sees her patient at each clinic attended, visits her in her home, teaches her in a group or mothers' club, gives nursing care to mother and baby during labor and the postpartum period in the hospital, follows her back into the home to give infant hygiene instruction and arranges for the mother's return for postpartum examination and infant welfare supervision. No major services such as tuberculosis, communicable disease or psychiatry are left out of the clinical experience of these nurses. Affiliations with teaching institutions are used to secure this. This is an expensive education for nurses to be sure, but is an education worth paying for. Can we not help to promote more of such schools throughout the country?

Fourth, we can increasingly demand special postgraduate courses as prerequisite for public health nursing positions. Then we can keep in very close touch with the directors of these courses, help them to know the practical problems from the field and urge them to teach the fundamental problems and principles of public health.

In the meantime: Until such time as we have nurses well equipped for public health nursing when they come to us, we must enrich their scientific background by our staff education programs. As a whole, nurses are exceedingly weak in scientific knowledge regarding nutrition, child development, tuberculosis, syphilis and mental health. Considerable experience in New York State over the past five years, with a continuous Statewide staff education program on the principles of public health and discussion *by the nurses* of how to put these principles in operation, has convinced us that this study program is markedly reflected in improved visits.

ENRICH THE SCIENTIFIC BACKGROUND

Here is the nurse who has had a great deal of trouble getting parents to use cod liver oil. True, she always told them that it was needed for its content of vitamin A, but that didn't seem to make any impression. Then, in her course in principles of public health, she was given a thorough explanation of the action of vitamin A in keeping mucous membranes moist and soft. It seemed to be easy for her to visualize its importance in relation to the conjunctiva which, without vitamin A, becomes dry, cracked, admits bacteria and results in an ulcer called xerophthalmia. It was then pointed out that in a similar manner the mucous membrane of the nose or throat may become dry because of

lack of vitamin A. It likewise cracks, admits the entrance of bacteria and results in infections such as colds, tonsilitis and sinus infections. "Why," said the nurse at the end of that explanation, "I believe I could get anyone to take cod liver oil now—knowing that!"

A knowledge of human relationships, including those involving the sex factor, is so lacking in the majority of public health nurses that it is almost impossible for them, without further preparation, to make satisfactory visits regarding the control of syphilis. They are educationally and emotionally handicapped. A group of 60 nurses about to graduate from five excellent schools of nursing were recently asked how syphilis is diagnosed. Not one mentioned the darkfield examination—our most important tool in early syphilis detection and control. Not one knew that the treatment with arsphenamines promptly renders the patient non-infectious and that he remains so as long as he keeps under regular treatment. Not one knew that syphilis is rarely, if ever, passed on to a third generation. Few, if any, knew that the spirocheta of syphilis is a very frail organism easily killed by soap and water, or by drying, and none knew that ordinary tap water alone promptly kills the gonococcus. These are the 1934 products of nursing schools! Just see how unprepared they are to help in the control of the greatest plague of mankind today. Yet as a result of a year of State-wide study on social hygiene last year, the growth of interest in that problem by nurses in our State is almost miraculous.

GIVE WIDER OBSERVATION AND EXPERIENCE

There are other methods besides classes and group discussion for staff education. One of the best ways to increase the nurses' practical information regarding child training and development is to have them observe or assist in a nursery school.* Yet I know one city with several excellent nursery schools and two large staffs of public health nurses, where never yet have these nursery schools been used for enriching the nurses' background. To say that one does not have time to send nurses there for observation is hardly a legitimate excuse when we see how much better visits have been made by nurses in organizations where this resource has been utilized. Staff education—yes, more than we think we can afford, is imperative until we accept on our staffs only nurses with special preparation for public health work!

Besides helping nurses to be better equipped with knowledge, is there anything more that we can do to improve results from our nursing visits, for after all, teaching content can only be measured by results. A great businessman has said, "I cannot commend any artificial plan for making men producers. You must lead them through self-interest. It is this alone that will keep them up to full capacity of productiveness."

A PROBLEM OF ONE'S OWN

Self-interest? Well, what is of vital interest to nurses—adult women? Granting some exceptions, educators tell us that the most consuming interest of an adult is to have a problem of one's own and successfully overcome it. Look over all the public health nurses you know and you will see at once that the ones who are most interested in public health work are the ones who have the most responsibility in solving the health problems of their locality. We usually think that they have that responsibility because they are interested. I should like to venture the suggestion that they are interested because they have that responsibility. Can we use that responsibility idea to improve the teaching content of a nursing visit and increase its productiveness?

From a practical standpoint, what results do we want from public health nursing visits? It seems to me that we want the objectives worked out by the National Organization for Public Health Nursing taken seriously and put into effect in every nook and corner of the United States. Have you read them just

*See PUBLIC HEALTH NURSING, May 1934.

recently and noticed how perfectly reasonable they are for any community? It is a thrilling job to solve the problem of putting them into action. My contention is that if each nurse could be helped to conceive of her own district or area as her own responsibility in which to get these objectives working, she would take an interest never before displayed or else she would soon prove herself incapable of doing so and worthy of replacement.

How could this be done? The first step would be to talk over these objectives with the local health officer to make sure that they coincide with his plans, and then institute a series of discussions on the problems in public health that would help each nurse to see for herself what the objectives must be. For instance, suppose you studied the maternity problem. Is it worth all the fuss we make about it? We have found it very impressive to point out the hazards of lack of care. First, we find the number of maternal deaths. We next remind ourselves of the thousands of children left motherless by this catastrophe. We also point out that for every mother who died, several were invalided, made incapable of taking good care of their children, as a result of which many more infants and children died or were less healthy. Besides these, there are the stillbirths, the majority of which could have been avoided if adequate prenatal care had been given early. Add to this the loss through abortions, which statisticians estimate at least 15 per cent of all conceptions, the neonatal deaths which, with the slightest amount of reasoning we must see are nearly always due to maternal factors, and you have in New York State alone a total of approximately 50,000 deaths most of which are chargeable to maternal causes, and the greater percentage of which are preventable! Compare this to other health problems and you will see that this number of deaths is almost as great as that of heart disease and cancer combined and about five times as many as all the common communicable diseases together, including tuberculosis. With such an analysis worked out for her own locality the nurse begins to see for herself why it is important for every expectant mother to be found early and placed under good prenatal care, and she is motivated to do everything she possibly can to overcome this big problem with her own group. Similar study can be made in every field of public health.

SELF-MEASUREMENT

The next step would be to familiarize her with the available standards of measurement for estimating reasonable accomplishments in health work. The A.P.H.A. and N.O.P.H.N. appraisal forms are comparatively new and less accurate than we hope will be evolved in future revisions, but they do serve as a guide and help to balance a program for the present. In some few instances where an entirely specialized piece of work is carried on, such as school work, perhaps temporary standards should be further worked out.

Now comes the real step in the program—assigning the nurse to her district for which she is to be responsible and asking her to estimate not only what has been accomplished, but what is left undone and how she proposes to meet the full health needs of her area. This may look rather difficult at first, but I suggest that it is well worth working toward. We have done it experimentally and both staff nurses and supervisors are enthusiastic about its value.*

THE SAME GOALS BUT A MORE EFFECTIVE APPROACH

In such a plan as just suggested, each nurse has an opportunity to do real problem-solving. Along with the greater interest that results there are inevitably other by-products not to be scoffed

*Such a study of an area will be facilitated if nursing districts are planned to coincide with town, village or ward division lines for which separate statistics are available. Some cities have recently seen the need of divisions smaller than wards for study and have divided the area into small "tracts" recognized by the United States Bureau of Census, by which all census reports are available. The city then keeps all morbidity and mortality records by tracts. In such a set-up, a study of health needs of a small area is simple. If the service is not generalized, it will be necessary for the several nurses working in any area to study the area's needs together.

at: the nurse starts searching for ways to make each visit more productive and lasting; she begins to see a logical reason for keeping accurate records; she looks for ways to save her own time for teaching and nursing skills by getting patients to do more for themselves and securing interested lay persons to help her with non-technical activities; she feels the importance of working on all of the health problems in every home she enters and teaching the family how to take care of similar problems in the future; she sees the need for group teaching to reach a greater number of people and she begins to ask her community for reinforcement in personnel to meet the urgent needs untouched. Do these sound familiar? They are, by and large, the same statements about the content of a good nursing visit suggested in the first of this paper, but they are no longer technics to be superimposed upon a staff nurse. They are principles which she herself has worked out in answer to her own needs.

Perhaps the most difficult part of such a plan is in ourselves—as supervisors—our inherent desire to do too much engineering. But if we decide to use such an adult method as this, we must go the full way: give the nurse the problem, the tools, and a reasonable standard against which to measure her progress, assure her by word and action of our willingness to assist her in planning at any time, and then be willing to step out of the picture (except to commend) unless she calls upon us for help.

It is not sufficient merely to start a nurse on such a program. Interest that is not fostered soon dies. It is the job of the supervisor to watch continually for every sign of progress or growth and encourage it. Favorable comment, group discussions in which nurses present the methods they have found useful or problems they have encountered for which they would like assistance from the group, and keeping of individual progress charts are specific ways in which this may be done. Besides this, a fountain of scientific information must be kept flowing from which the nurse may continually gain inspiration and refreshment and increase her fund of knowledge from which to teach. Thus enters the continuous staff education program.

These, then, are some of the things which I have thought important in improving the teaching content of public health nursing visits. Time has permitted few details—only the proposal of certain trends and principles. I have not touched on the personality of the nurse or teaching methods. Do not think I have thought them unimportant. I make the plea that public health educators and supervisors bend their efforts to improve (a) the selection of students as prospective public health nurses, (b) the basic health knowledge and viewpoint in schools of nursing; that we supply an increasingly good teaching fund of knowledge by continuous staff education on the problems and principles of public health; that we use an adult method of promoting genuine interest in nurses; that of making each responsible for the full health needs of her area or district,—not for the purpose of driving her to meet certain standards but for giving her the thrill of problem solving in health work and that we foster this interest by watching for signs of growth and encouraging them.

Much that I have told you make up the actual program and plans of the Division of Public Health Nursing in the New York State Department of Health. For those relating to a thorough-going staff education program on the problems in public health, we are particularly indebted to the vision of Ada Boone Coffey; others are products of our district and consultant nurses. Believe me when I say that we were never more serious than we are now in asking for your frank criticism.

Public Health Nursing Service in Small Industries

By GLENN S. EVERTS, M.D.

Industrial Physician. Formerly with the Philadelphia Health Council and Tuberculosis Committee

We have been waiting for this article for a long time. We believe the practical demonstration and testimony to success of this plan for using public health nurses in small industries will be welcomed by many of our readers to whom the idea has occurred, but who have perhaps been reluctant to experiment.

IN order to make intelligible the inception of the use of the visiting nurse in part-time industrial health work in Philadelphia it will be helpful briefly to summarize the seven-year demonstration of that work by the Philadelphia Health Council. The Visiting Nurse Society is now providing nursing service in four of the plants whose medical department was instituted by the Health Council.

THE DEMONSTRATION STARTS

In January 1926 the Philadelphia Health Council and Tuberculosis Committee began a demonstration of the practicability of part-time health service among plants employing from 100 to 500 persons. In December 1932 the demonstration was completed. Services had been organized in 31 plants employing 9,721 persons. Today 14 are still in full operation notwithstanding the economic depression which, so far as can be learned, remains the single reason for the suspension of services in the other plants. Of the present 14 plants, 10 are larger ones employing 300 or more persons while four are smaller employing in one case as few as 80 persons. The service of this smallest plant is entirely maintained by the employee beneficial association.

The procedure adopted by the Health Council in instituting these health services has been told before. Briefly it consisted of grouping two or more plants having from 100 to 500 employees into a single unit for joint health service. This was spoken of as an "industrial health unit". The more closely located the plants were to each other, the better. Each unit was to consist of approximately 1,000 employees. One full-time industrial nurse, if her time were carefully scheduled, could successfully serve that number of employees and do the necessary travel between plants. One-half time of an industrial physician likewise was found to be sufficient for that number of employees.

Each plant sharing in the unit service agreed (1) to provide one or more clinic rooms at the plant, and (2) to pay monthly their pro rata share in the maintenance of the unit based on the average number of its employees. The service rendered the plant was comparable in scope and quality to that of many larger industrial medical departments considering the fact that it was on a part-time basis. The amount of service was determined by the number of employees in the plant. For every 100 employees the plant received one hour physician's service and two hours nursing service, the nurse's schedule being arranged so as to coincide with the schedule of the physician.

Since the work was in the nature of a demonstration on the part of the Health Council it was not considered as complete until the service had been transferred to the administration of the plants themselves. The procedure of transferring a unit, together with the half-time doctor and full-time nurse, presented a problem of considerable detail. Whatever revision in one or two plant schedules was advisable usually

meant a rearrangement of all the plant schedules with a consequent change in the prorated share of salaries. And the details of these changes in schedule and prorated share of salaries had to be considered by each plant and agreed upon before the unit could be transferred intact.

PART-TIME SERVICE DIFFICULT TO SECURE

The one fundamental reason for the grouping of two or more plants together into an unwieldy unit of about 1000 employees was the necessity of providing a full-time job for the industrial nurse when the unit was finally transferred to the plants. Until the Health Council, one by one, could interest two or more smaller industries in establishing a medical department the extra time of the engaged nurse would have to be utilized in some less satisfactory manner. Seven years ago it would have been difficult to have engaged a first class nurse for part-time work and even now, were the demonstration still being made, the probability of a part-time nurse taking some other full-time job while she waited for new plants to be added to her schedule would jeopardize the continuity of effective nursing service to the industry. From physicians in private practice, on the other hand, many could be chosen who had an interest in industrial health and who would take over the schedule of the Health Council physician for either a single plant or a unit of plants according to the amount of time they cared to spare from their usual work. And so the problem resolved itself into finding some simpler and more economic way than the unit plan of carrying along these health services and turning them over after a period of supervision to the management of their respective plants. The problem chiefly seemed to be one of nursing service.

Just when, how or to whom did it first occur to adopt the flexible nursing service of the Visiting Nurse Society to answer that problem, the author is not prepared to say, but being intimately connected with the entire project both during and since the suspension of the demonstration he can testify to the success of the plan in every particular. While the thought is in mind, however, it may be well to add here that the real test of the nursing service of the Society in this part-time type of work will be more appropriately measured when one of its nurses will have had the opportunity of serving a plant with a physician who has a private practice and whose interests are inevitably divided rather than as it is now with a physician giving full-time to industry and being peculiarly interested in the success of the work. If that visiting nurse whose interests likewise will be divided can assume the burden of administrative responsibility in the plant and three-fourths of the initiative and enthusiasm to make progress in the work then, in my opinion, the Visiting Nurse Society will have qualified to do industrial health work in smaller plants. It is to be hoped that some day such an opportunity can be made possible.

When in the fall of 1932 the Health Council planned to terminate its demonstration there were two full units to be transferred to the plant managements. Due to the marriage of the nurse of one of these units it was decided to request the Visiting Nurse Society to furnish the nursing service for the four plants in that unit. This was very satisfactorily arranged and in October the change was made. Two months later, when it was felt that the new nursing service was functioning smoothly, all the plants in this last unit were turned over to their respective managements. Both the physician and the Visiting Nurse Society from then on were paid directly by each plant according to the amount of service given, and were responsible to each plant for the future success of the work. The transferring of this last group of plants was done for the first time in the seven-year demonstration period without having to worry about the usual readjustment of schedules to fit into the time of a single nurse who could not be two places at once.

In the beginning the Visiting Nurse Society selected only two nurses to do the work in the four plants but later it was found more satisfactory, from the standpoint of less overtime in favor of

the industries and continued interest in their regular field work, if one nurse were scheduled for only one plant. Later on an alternate for each nurse in each industry will probably be trained not only to act as a substitute in case of illness, "long days", or the vacation of the regular nurse, but to constitute a source to the community of industrial nursing service. This service could be available to a small plant about to establish a medical department and needing only a few hours a week or to a larger plant needing considerably more time for some short period of emergency.

The four plants in which a Visiting Nurse Society nurse is now scheduled are as follows: One pork packing plant of about 425 employees in which the nurse is serving half-time every afternoon for five days a week and two hours Saturday morning; another pork packing plant of 500 employees with at present only the original eleven hours per week nursing time; a baking company of 300 employees with ten hours per week; and an iron works of 80 employees with two hours per week. Each nurse goes to her plant according to schedule throughout the week but, allowing for her time in the plant and travel time, she is assigned an appropriate amount of field work the same as the other nurses. Her duties in the plant are the duties of every well trained industrial nurse which have been repeated in literature many times. In an article entitled "Public Health Nursing in Industry" (Hygeia, February 1934) Violet H. Hodgson, former assistant director of the National Organization for Public Health Nursing, gives a very comprehensive summary of the possible scope of the work of an industrial nurse.* And especially in this small plant work, the nurse tends to become the key to the permanent success of the service even more than does the physician because she must assume not only the nursing duties but also the administrative duties as well and in addition keep a fairly complete set of records of everything that is done by both herself and the physician. The job is one of no little responsibility.

ADVANTAGES OF VISITING NURSE SERVICE

And now if I were asked to appraise the use of the Visiting Nurse Society in small plant work in Philadelphia over the past eighteen months I should enumerate the following advantages: First, the continuity of service, assuring an alternate nurse at the plant in case of illness, days off, or vacations. Second, the flexibility of the nursing schedule. This was particularly demonstrated in August 1933 when it was easy to change the nurses' time to meet the changed hours of the employees. Third, the general advantage of public health training which implies, among other things, a detailed knowledge of clinic, hospital, and other facilities in the community and how to use them. Fourth, available help in follow-up work in the home on cases far removed from the district of the plant nurse. (By special request an informational visit can be made by a nurse in the district in which the patient lives.) And last, the added incentive to make a success of the work which comes from belonging to, and doing that work for, an organization, even though direct supervision of the very different work in industry is especially difficult.

But there is one major factor which, in my opinion, the acquisition of all these organizational advantages can not counterbalance and that is in the selection of the nurse herself. Much has been written about the desirable characteristics of a good industrial nurse and still not too much has been said. Experience with many nurses has proved that a nurse possessing certain personal qualifications but lacking special knowledge of industrial or public health work will very shortly make a more successful nurse in industry than if the reverse were true. Up to the present time the Visiting Nurse Society of Philadelphia has been extremely fortunate in the selection of their four nurses in industry.

*See also Mrs. Hodgson's book, *Public Health Nursing in Industry*. The Macmillan Company, $1.75.

Not only do they have the personal qualifications of a good industrial nurse but happily they have the initiative to apply their public health training to the job at hand and the continued success of their work is doubly assured. It is to be hoped that at some future day the Philadelphia Health Council can continue in its promotion of medical services in small plants and will be able to make use of the nursing service of the Visiting Nurse Society to an advantage only learned in the later days of its demonstration.

Nursing in a Camp for Homeless Men

By E. C. MILLER, R.N.

Camp Treaster Kettle, Centre Hall, Pennsylvania

So far as we know this is the first article we have had—at least in recent years—from a male registered nurse. Mr. Miller reports on the opportunities to teach health and prevent illness in one of the emergency relief camps for homeless men, at Centre Hall, Pennsylvania.

SINCE this depression there has opened a new opportunity in nursing. Under the State Emergency Relief Boards, there have been established through various states, camps for homeless men. Into these camps come men who, to use their own terms, have been down and out for several years. Men who, financially unable to secure medical attention, are under par, who, through the loss of all that life held dear to them, have become "nervous wrecks," not subjects for psychopathic wards, far from it, but tragic figures in discouragement and failure. The intelligence test given these men shows a higher percentage of mentality than among some of those holding good positions, but they are depressed.

Recently, a young lad in his early twenties came into our camp, very reticent and as they say in the underworld, "a lone wolf." He was melancholy and had those "blue spells" which are so well known to most of us. He came into the dispensary one evening for a dressing and I, being alone, had the opportunity to draw him out of himself. The story he told me was pathetic, but I had an insight into the boy's past life. Twenty-two years of age, good home, father and mother, a good education and a position paying a fair wage. The parents thought he was too much of a "sport," and censured his actions and spendthrift ways and the lad, becoming angry, left home. The usual story: freight trains and all that goes with them, then a Transient Bureau, and then the Camp. He refused to become at all coöperative with the personnel men, but after I had had this little chat, I was able to relay the story to the Personnel Department. A letter went home and the reply stated that his family wanted him back. Transportation was given and the boy reunited with his family. This is only one case out of many.

CAMP ROUTINE

When a man enters Camp, he undergoes a physical examination which determines his fitness for being classified for duty. A Wassermann sample is taken and complete immunization against typhoid and paratyphoid is given in three separate doses, from seven to ten days apart. If the Wassermann is positive, treatment is begun. All gonorrhea suspects have smears taken and if a man with positive G. C. is found, he is segregated and treated. When the disease is no longer found by microscopic examination, he is given light duty until he is able to return to camp

routine. The camp we were in before we came here had a capacity of five hundred men and we had only about one per cent of venereal disease infection, which shows that although a man may be forced to roam from place to place before he finally locates himself, he has self-respect enough to keep a clean slate.

A tent is erected for the one tuberculosis case that we have at present and all the requirements of the State Health Department are met.

A well-arranged kitchen provides diet facilities and a special hospital table in the mess hall is provided. Men unable to attend these meals for any reason have trays sent to the ward.

Our present camp capacity is two hundred and the men are a very healthy lot. Two sick calls are held daily and only emergencies are taken care of between hours. We have a well-equipped drug room and are able to meet practically any emergency that might occur. Being in rattlesnake country, lectures on snake-bite are given the men so that each man is instructed as to the procedure of treatment until he can be brought to the camp hospital, where snake-bite anti-venin is kept ready.

THE NURSE'S OPPORTUNITY

A nurse not only administers medical aid here, but can, through tact, gain the confidence of the client and thereby aid the personnel staff of the camp. Remember there is, or ought to be, a direct coöperative spirit between the nurse and the social service worker. None of this petty antagonism should exist. The case worker is there to aid the man by securing employment, provide the right sort of recreation for him, and, oft-times, a nurse can be of great assistance by interviewing the man. The man may be reticent, hate to confide in the personnel department, but will confide in the nurse. Why? Because if you are tactful, you can, through your nursing, gain the patient's confidence; and remember, every man's case has its own story. To him, it is the so-called skeleton in the closet.

A few of the men have the complex that they have been given a raw deal, and they seek revenge, having an intense hatred for all who, as they say, are to blame for their present condition. You may say it's only imaginary —to you, yes—but to them, it is very real.

Take for instance, a man who, through complete loss of everything, has become, as we would term it, a "psycho." He needs more than medical treatment. You can, if you wish to do so, cultivate a friendship which will become of vital importance to his welfare. Athletics are more beneficial than pills here. Swim with him, play ball with him, climb mountains and become a part of his life and thoughts. Learn his troubles and then help him to rid his mind of the existing trouble, real or imaginary. You cannot heal a wound with infection existing. Neither can you heal a mind with these conditions existing.

Our recreation hall contains a piano and many of our men are good musicians and often an old-fashioned sing breaks the barriers down and the pent-up emotions are freed. As a violin string is loosened before putting the instrument away, so are the nerves loosened and before long, light-heartedness replaces the feeling that the world is against you, and everyone is happy. Help keep the spirit of contentment and you are doing much toward keeping the health of your patient.

A nurse should be able to be both professional and a good nurse in overalls as well as in a stiffly starched uniform, for the white uniform does not make a nurse. You are often called upon here to do things that you are never called to do in other hospitals; be capable of handling the situation. In the absence of the physician, you are called sometimes to render a decision which may seem beyond your ability—thus a nurse learns to stand on his own feet.

The physician in charge of this camp, through his World War experience, has learned to know and understand men. He is a man who is never too busy to listen to a tale of woe and advise as only a father can, calm and collected at all times, no matter what the emergency

may be. A man of kindness, yet firm.

In summing up, I have tried to show briefly the value of the experience a nurse can get here or in any other camp, and just what complete coöperation means in all the departments of the camp. One can, through willingness to help all concerned, make life a different story for the man who has been down, but is never out.

Supervision of Supervisors

By ANN I. LEONARD

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IT has been generally conceded that supervision needs evaluation. In the past a great deal of attention has been given to the results obtained through supervision but little consideration has been given to the supervisor who must accept full responsibility for the results. This seems to be true in public health nursing as well as in other fields of the nursing profession.

WHO SUPERVISES SUPERVISORS?

The analysis and evaluation of the supervisor arises from three sources:

The staff group
The supervisory group
The administrative group.

The judgment of the majority of the staff who are supervised is a very valuable source of information concerning the worth of any supervisor or her program. While this is difficult to secure, this opinion should not be neglected. It is valuable because it not only promotes an open and honest expression of opinion, but also helps to prevent an unfair and under cover criticism which often exists. Some far thinking supervisors have devised a method by which their staff are able to critically analyze their supervisor and her work. An opportunity is given to them to express their opinion of her success or failure. The staff is also a reflection of the supervisor in the community and often brings back the community's reaction to the organization.

It is assumed that the supervisors themselves engage in self-rating and self-analysis and in this way help to promote self-improvement to a greater degree. Obviously, too little of this has been in effect. A more or less dependence on the "other fellow" to judge has evolved. The ability to analyze one's self is a rare but necessary asset and more effort should be expended in its interest.

In order to further improve the functioning of supervisors there should be a consciousness on the part of the administrative group of "commendation of good, condemnation of bad; and suggestion of the better."* Just as a feeling of *rapport* is necessary between the supervisor and her staff, so is such a feeling essential as a workable basis between administrator and supervisor. Administrators are responsible to the public and therefore should be vitally concerned with the efficiency of supervision which plays such a large part in the service to the community.

It is the last of these sources, the analysis and evaluation of supervision by the administrator, with which this article is mostly concerned.

WHY SUPERVISE SUPERVISORS?

It is assumed that the supervisor has been wisely chosen as regards educational background, professional training, experience and adaptability for the position. Since the philosophy of supervision of a staff implies that supervision is essential to efficient results, then it naturally follows that supervisors should feel a need and expect and welcome

*Barr and Burton—Supervision of Instruction. Appleton.

supervision from one of a hierarchy. The term hierarchy is not to be confused as meaning an unsurmountable barrier but rather a recognition of a superior ability and experience.

In the introduction of an assistant supervisor considerable time is given to her development at that stage, but after that she is responsible for her own advancement and continued growth. This of course is a considerable challenge to the individual, but even public health nursing supervisors are human and need a bit of encouragement and stimulation at times. The supervisor who is constantly trying to create new interests or renewed interest among her staff, greatly appreciates any commendation of her efforts. Some will argue that if she is a good supervisor she should be satisfied with knowing that she has developed each of her staff to their greatest capabilities. This is true but not sufficient. Some supervisors are too easily satisfied and coast along, never realizing that they are doing an inferior job; while others can never judge their own abilities and have a tendency to exhaust themselves and their staff trying to ascend heights possibly unattainable.

A more definite schedule or method of supervision might be developed for supervisors. The occasional contact with any member of the administrative group is always stimulating and leaves one with the desire to make these contacts more frequent and at regular intervals.

HOW SHALL SUPERVISORS BE SUPERVISED?

The supervisor should be observed in as many situations as possible, as this makes for a more complete picture of that individual. It would help to prevent a distorted picture that a supervisor may present to her director by always telling her the best things she has been able to accomplish but never mentioning the difficulties or antagonisms she has aroused by accomplishing them. On the other hand it gives the supervisor who is shy and reluctant to tell of her achievements, an opportunity to show her director the type of work she can do. There are necessarily individual differences and supervisors vary in ability to carry on all phases of their work. One may be better able to maintain a fine morale in her office and do a satisfactory piece of work, while another supervisor may do an excellent piece of work as judged by her administrators and yet may not have the ability to recognize an undercurrent of restlessness and discontent in her office. In developing morale a supervisor may be able to give her greatest contribution to efficiency of the staff and improvement in the general service. And yet how many supervisors overlook this opportunity in their rush to obtain the maximum number of visits, supervise routinely at regular intervals on every type of case whether or not it is convenient for the nurse.

SUGGESTED AIDS

The following suggestions are offered as aids in improving the supervision of supervisors:

1. "Talk-it-over" conferences for supervisor and members of the administrative group. At these conferences the supervisor could explain special projects which she is planning, those projects already carried out, or special problems needing help. The conference should be at the request of the supervisor and not by the administrative group. This would promote more freedom for both.

2. Visits should be made to the local office by the administrator to observe the supervisor in her daily environment. Particular notice should be given to her contact with the nurses and the administration of her routine office work.

3. The supervisor should be observed in contact with coöperating agencies. This would show the supervisor explaining policies of the organization and the part she plays in the community.

4. The supervisor should be observed in contact with her lay committee. This may reveal the supervisor's interpretation of the service.

5. The supervisor should be observed in group conference. Are the decisions reached those of the group or those of the supervisor?

6. Observations of other nursing organizations in action should be provided or encouraged. This would help to give a broader point of view to the supervisor.

7. Attendance should be encouraged at conventions, meetings, exhibits, lectures and round table discussions.

8. Special lectures should be provided per-

taining to the latest developments in allied fields.

9. An opportunity should be provided to see or hear about what other supervisors are doing in one's own organization.

10. An opportunity should be provided to change a supervisory area—after a reasonable length of experience in one area. One supervisor should not feel that she is indispensable to an area nor should she feel that her work is unsatisfactory if she is requested to accept another area. She should welcome this as an opportunity to develop herself further.

11. All supervisors should be encouraged and urged to take postgraduate classes. The importance of improving supervision through further education should be emphasized.

12. Regular meetings of supervisors and administrators should be held for discussion of general organization problems and actual participation in the determination of the policies.

13. Supervisors in general feel a need for the evaluation of their work. Possibly for the first year or two a semi-annual evaluation of work would be satisfactory.

14. Annual evaluation of the work should be made after first two years.

Through the combined efforts of the staff, supervisory and administrative groups, the functioning of the supervisor could be improved. There seems to have been a decided emphasis placed on guidance of the staff by supervisors, but there has not been a relative guidance of supervisors. Supervision itself is an extensive project and its supervision would necessarily be even more extensive. The cost of such a program can not be disregarded, but the results ultimately would balance this.

COMMENTS FROM AN ADMINISTRATOR

Miss Leonard's article on the "Supervision of Supervisors" is stimulating and thought-provoking. Of course supervisors need supervision as do administrators and all others who are engaged in community service. We are only too apt, I think, to act as if we regarded the supervisor as a person who has somehow 'arrived"—but at what level?

It seems to me that the district supervisor, in the generalized service, as well as the supervisor of a special service, is usually chosen because she has given evidence of *administrative* ability. She is a person who has managed her own work well and should, therefore, be able to guide others in similar activities. The supervisory assistance that she herself receives is usually directed toward growth in *administrative* ability. But, as Miss Leonard points out, the problems of supervisors are complicated by the difficulties inherent in the establishment and maintenance of the right sort of relationships in the group supervised. How shall the supervisor of today, who was the staff nurse of yesterday, be assisted in her efforts to improve the service rendered by the staff as a whole, through the growth in service of the individual workers? It seems to me that one difficulty in public health nursing supervision is that we give so little attention to educational supervision of the type that has been developed in certain school systems, and in social case work—not "staff education", in the sense of making up deficiencies in the nurses' basic training, nor the initial preparation needed for work in a specific agency, but the constant, constructive appraisal of the work of the individual, and the agency, by a supervisory person or group, freed from direct administrative responsibility. We have developed head nurse positions in public health, it seems to me, rather than true supervisory positions, and need, perhaps, "helping" supervisors who can work with, and through, the district or special service supervisors and the staff workers, for the constant improvement of the quality of the service rendered.

Our "educational" supervisors belong in such a group, although they are still pretty busy with educational work of a preparatory nature. Our consultants from other fields, nutrition, mental hygiene, and parent education, are true supervisors in the sense indicated in that they focus their attention on the improvement of the work by their contributions in subject matter, and methodology. Perhaps we need nurse supervisors similarly freed from major administrative responsibility who will help in the process of integrating all of these technics from related fields in our philosophy and practice of public health nursing.

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The Volunteer—Asset or Liability?

By EVELYN K. DAVIS

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IN the recent *Survey of Public Health Nursing*,* the following statement pointed out the value and use of volunteers:

"Another advantage in contact with lay organizations is the direct participation of individual members in the activities of the public health nursing agency—although such participation should not be limited only to members of these organizations. There are again wide differences in the extent to which such volunteer services are used by the agencies studied. As might be expected, the differences parallel those already mentioned—a larger proportion of public health nursing associations than departments of health use volunteers, while boards of education use them very rarely. *As this contact with the citizens of the community through organizations and as individuals offers an exceptional opportunity for both official and non-official agencies to interpret their program and to get the backing of taxpayers and contributors as well as to utilize the services which they give as volunteer workers to the agency, it seems a pity that such relationships should not be developed more actively and consistently by all agencies concerned.* The committee recognizes that any carefully developed plan of public education through groups or through the participation of individuals in the work takes time and energy. It feels that this would be time well spent and a legitimate part of the agency's program, as it may mean the extension of the service through the support of public opinion as well as through practical assistance given." (The italics are ours.)

A PLAN ESSENTIAL

In order to make volunteer service effective in any public health nursing program, a carefully worked out program is necessary. A chairman of volunteers should be appointed who is a member of the board of directors, and there should be a member of the professional staff, either the executive director or someone appointed by her, to be responsible for the volunteer program of the organization. The professional member of the staff assigned to this program should be one who has a real understanding of volunteer service; who is thoroughly convinced of the value of volunteers; and who has the ability to interest and train the lay worker in the program. Too often volunteer service is felt to be something the organization should have, but a careful planning of the program is left to chance. A volunteer comes in with the idea that she is going to be of service and is given tasks which she knows are thought up to keep her busy; or is assigned jobs to carry out which she cannot do well without instruction. The volunteer has a real contribution to make to the program besides extending the effectiveness of the work. She can be one of the best interpreters the organization has for working actually in the program of a public health nursing organization, she should be able to describe the work to the community at large; but she will not do this satisfactorily or correctly unless she is made a part of the organization itself.

STEPS IN DEVELOPING A VOLUNTEER PROGRAM

Finding the Job: The first task is to find jobs. This is the professional supervisor's duty. She needs to sit down and carefully analyze the whole program of the organization to see what jobs could be done by the volunteer. Members of the staff should also be consulted about finding jobs, in fact, it might be a project for a staff conference. The job should be listed and described; the amount of time it is going to require to carry it out, the frequency of the need (once a week, once a month, etc.), and some of the qualifications necessary for a volunteer who is going to do it. There should be jobs for the volunteer who wants to be given definite hours, and for the volunteer

*The Commonwealth Fund, New York, N. Y., $2.00.

who cannot be regular but has time now and then to come to the office. The volunteer who can give three or four weeks to a special project should be considered as well. The younger volunteer will want to feel that as she becomes more efficient in her work, she may be advanced to a more important task; that experience and training count in the volunteer job as much as in the paid job. For this reason, the professional supervisor should indicate which are the harder, more advanced jobs to be done by experienced volunteers, and which are easy starters. The professional supervisor comes to realize that there are actually many volunteer jobs in public health nursing organizations when she approaches these possibilities with conviction.

Recruiting the Volunteers: After the jobs have been listed and defined, the next task is in the recruiting of volunteers. This is not a professional responsibility, but is the duty of the chairman of volunteers. She takes the list and definition of jobs and makes contact with possible volunteers. Sources for volunteers are many and should be representative of all the groups in a community. The first is the board of directors itself for often there are members of the board who crave some definite task in the work of the organization.

Another contact is the Volunteer Placement Bureau in the Council of Social Agencies, if there is one in the community. More and more, councils of social agencies are developing these bureaus where they have a well prepared placement secretary to recruit, train, and place volunteers in the various organizations. Another source is the Junior League, and the chairman of volunteers should make contact with the placement chairman of the Junior League whose task it is to find jobs for Junior League volunteers in the agencies in her community. More and more emphasis is being put by the National Junior League on the need for careful placing of volunteers and also on finding jobs for the volunteer which will be educational and give her some real knowledge of the work of the organization in which she is giving her service.

Other sources are various clubs, such as the Kiwanis, Rotary, Lions, etc., church groups, and P.T.A.'s and women's clubs—and we don't want to limit our volunteers just to women for some very good men volunteers have been used in motor service, publicity programs, etc. It is possible to try some form of advertising for volunteers such as an article in the newspaper. One large city organization had notices sent out with the bills from one of the stores. A contact with business women as well as those of the leisure class is a good step and frequently stenographic workers can be found who are desirous of having experience before taking a regular job or who are unemployed and would like to keep their hand in for the time being, or those who are trained but are not looking for paid employment at the moment.

Placing the Volunteers: The first weeding out of the volunteer group can be done by the volunteer chairman. The next step is introducing the volunteer to the professional member of the staff in charge of volunteers. A definite appointment should be made for the volunteer with the professional supervisor and the first interview with the worker would be conducted just as in interviewing a paid member of the staff. The chairman of volunteers should have gathered some information about the worker, such as her general interests, possible training and experience; but it is necessary in the interview before placement to find out what particular interests the volunteer has and what special abilities so that the placement will take all of these factors into consideration. The professional worker would emphasize the standards and program of the organization; the need for recognition of the fact that all relationships with clients are of a confidential nature and that while the volunteer is working for the organization she must have a professional attitude toward the work and her particular part in it. Some organizations gather references for volunteers. This places the job on a serious basis as well as giving some indication of the abilities of the volunteer. The more professionally the whole pro-

cedure is handled, the more the volunteer feels a sense of responsibility and the importance of the job she is going to do.

If the volunteer is going to work in the office, or going in and out of headquarters, it is important to see that she has a table, desk, or corner that she can call her own; to see that she is introduced to those with whom she will have contact so that she feels a part of the organization staff.

Training the Volunteer: By the term training, we mean, first, giving the volunteer a picture of the work of the organization and showing her how her job fits in, so that she will be an intelligent interpreter and worker; also, special preparation is needed for the volunteer who is going to do a special piece of work, such as clinic assistance, home visiting, assisting the nutritionist, etc.

We offer here several suggestions for training the worker and keeping her informed about the program of public health nursing as a whole.

A general introductory series of talks may be given—four or five talks or discussion meetings—bringing out such points as the history of the organization, the organization of the board and staff, and how the work is financed; the preparation and functions of the professional staff, and an outline of the services that the organization offers, with office demonstrations of the actual work of the staff, such as home visits. The study outline, which was worked out for board members two or three years ago by the N.O.P.H.N., could be used in these talks, and is obtainable through the N.O.P.H.N. office. In the October PUBLIC HEALTH NURSING, there is a suggested outline of what a board member should know about the organization, and this could be used for volunteer workers.

If the volunteer is going to do special work in a clinic, one or two talks on the value of clinics, their purpose and plan, and the part they play in the whole public health nursing program could be given to the worker, followed by an outline of clinic routine and the volunteer's duties. (See page 601.)

If the volunteer is doing motor service, some brief resumé of the case which the volunteer is taking to the clinic should be given her; or if she is driving the nurse around on some of her home visits, the nurse can give her a picture of the work she is doing in the families she is visiting. The volunteer is going to be more interested in doing motor service if she has some conception of what is happening as a result of her help.

If the volunteer is going to do home visiting, it is essential to have some discussion meetings on the technique of visiting. How to approach the family in the first interview, etc., would mean much to the volunteer who is going out to visit a shut-in or to do follow-up work for the clinic. Some volunteers, of course, have done this in the case-working field, but by and large, they will be coming to the work without experience along these lines.

If a group of volunteers is making supplies, a talk can be given from time to time pointing out the use that is made of the materials and a general picture of the work, so that they have more interest in what they are doing and so that they too can talk intelligently about the program.

Occasional group meetings of all the volunteers are extremely valuable in keeping them in touch with the work and in giving them an opportunity to ask questions that have come to their minds during their period of service. An invitation to attend staff meetings will bring them in closer touch with the work of the nurses and an invitation occasionally to attend board meetings when general subjects are being discussed, is a valuable way of orienting the worker. The point that needs continual emphasis is the importance of keeping the volunteers closely in touch with the whole program so that they will see how their tasks benefit the whole.

Management: The volunteer chairman should keep a card file of all the volunteers who are interested in working in the organizations and it is her responsibility to search for the worker

for motor service or the substitute for clinic, etc. Also, if the volunteer is not satisfied with the work she is doing, it is the responsibility of the chairman of volunteers to talk with her and make recommendations for a possible change into another activity if a more satisfactory placement can be made. If the volunteer is not satisfactory, the professional supervisor should report this to the chairman of volunteers who can talk with the volunteer, and, if need be, ask her to resign if she is not going to be able to do the work satisfactorily. It is better for the volunteer, and certainly for the organization, for her to be carrying out the work she is best fitted to do, so the more carefully we approach this whole subject, the more satisfactory the work will be.

Volunteers are excellent sources of material for board membership and by having the chairman of volunteers on the board, and making regular monthly reports to the board about the volunteer program, she can keep the chairman of the membership committee in touch with the volunteer workers who are proving satisfactory and who are of the calibre to serve on the board.

Some of the volunteer services which have been developed are the following:

CLINIC SERVICE

If the agency is carrying on a clinic or conference program, there are many ways in which volunteers can be used. "They may serve as hostesses, greeting the patients as they come in; seeing that their records are taken out of the files; that they are assigned a number to go in to the doctor; and that they are comfortably seated and made to feel at home. They may weigh and measure the babies or preschool children and assist in taking the doctor's dictation if it relieves the nurse. The clinic volunteer should be trained to do any task that will release the nurse so that she may have more opportunity to spend in the interviewing, and instructing the parents, and consulting with the doctor." The nurse's primary concern is with the instruction of the patient; her mind and hands should be freed from the machinery of the clinic.*

*Instructions for clinic service might cover such points as the following:

Attendance: The value of volunteer service depends upon its regularity.

(*a*) The clinic begins at .... o'clock. Please be on duty at that hour unless you have made other arrangements with the nurse.

(*b*) If you cannot attend the clinic, please notify the chairman of volunteers at least a day in advance so that she may obtain a substitute.

Dress

(*a*) Please wear an apron or a smock. This is to serve as a distinctive uniform for the volunteer. It establishes her as a part of the clinic staff and tends to make patients more comfortable. It is best not to wear elaborate jewelry.

(*b*) Please remove your hat.

Relationships

(*a*) You are part of a professional service and your contact with the client may determine whether she returns or not.

(*b*) The best way to gain the confidence of a mother is to take an interest in her baby.

(*c*) The nurse is the person to give health information and therefore you refer all questions to her. You may cause confusion by comments either in weighing or in the examining room.

(*d*) Personal affairs should not be discussed before the mothers.

Duties

(*a*) Reception Clerk
Mother received and registered.
Record obtained if an old patient and if new patient send to the person taking histories.
Assist mother in undressing and dressing babies.

(*b*) Taking Histories
All histories should be taken privately. In most clinics this is done by the nurse, but a volunteer can be trained to fill this job very satisfactorily. The information should be concise and complete and tact should be exercised in asking questions.

CLERICAL SERVICE

Here there is a real opportunity for helping in the organization's program by using volunteers in the office. They can relieve at the switchboard; they can help with typing records (the volunteer of course will be instructed that all records are of confidential nature); with summarizing daily, weekly, monthly, and annual reports; they can do some work on filing (one volunteer in an agency completely revised the files and helped to bring them up to date where they had very little clerical service in the office). They can help with making charts and graphs and posters in connection with any reports for publicity, annual meetings, clinic instruction, etc.

PUBLICITY

Usually publicity is the responsibility of a committee but there are many ways in which volunteers can be used in carrying out the program. Those who have artistic ability can be asked to help in making posters and in planning and setting up window exhibits. Those who have ability in writing could take some of the case studies and reports of the organization and write newspaper articles. One organization has had a small column in the newspaper for five years, reporting on various phases of the work of the organization, and this can easily become a project for a volunteer who has talent and ability along those lines. The putting on of plays can be the project of a Little Theatre group in the community which can thus make their contribution to the organization. Those who make good speeches can be trained as volunteer speakers before clubs, church groups, and similar organizations, speaking on the work of nurses; or they can work up a radio broadcast once or twice a year. The office scrapbook containing all publicity releases and leaflets should be kept by a volunteer. Such a book is invaluable in planning the next year's program and as a reference book.

MOTOR SERVICE

Too often the staff of the public health nursing organization spends a great deal of time in the transportation of patients to clinics or distant hospitals, etc. By securing volunteer motor service there can be a very definite monetary contribution made to the organization in saving the nurses' time and allowing them to give more nursing service to the community. Of course the policy of the organization is to place more and more responsibility on the family to attend clinics, etc., but there are cases who cannot possibly get there unless offered transportation. The difficulty in arranging motor service is to find people who can be regular and are willing to do this type of work. It should not be the task of the professional director to telephone here and there trying to get a volunteer, but it is suggested that the director plan ahead as far as possible when cars are needed, as it is always difficult to get someone to drive at the very last minute. If there is a regular day for making trips to certain hospitals or clinics, for example, it is often possible to have a volunteer take care of all transportation.

The question is often raised by the volunteer as to the possibility of accident and her responsibility. The volunteer, of course, runs this risk at any time in taking any one in her car, and her own personal insurance would only cover a personal suit. One community took care of the matter by having the

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(*c*) Weighing

1. Be sure that the scales are properly balanced. Accurate weighing is absolutely necessary no matter how long it takes.
2. All clothing must be removed before the baby is weighed.
3. Make necessary changes of weights smoothly without sudden jarring, which might frighten the child.
4. Further details of procedure will be explained by the nurse.

(*d*) Doctor's Dictation

A volunteer can be trained to assist in the examining room by taking doctor's dictation. Many associations work out a list of abbreviations of words used in this examination which will facilitate matters for the volunteer.

Judge of the Children's Court appoint a volunteer motor corps as special deputies of the Children's Court when they were taking crippled children to the hospital, as they did regularly each week for treatment. Another community had cards which the patient signed before getting in the car saying that they would not hold the driver responsible for any accident incurred while she was taking them to their destination. Of course, volunteers should be selected carefully and only those used who are experienced drivers who will take every precaution against accident.

MOTHERS' CLUBS

Teaching sewing to a group of mothers, helping them make their layettes or supplies for the new baby, may well be done by volunteers; or entertaining children while mothers are meeting with the nurse in a mothers' club or clinic.

FRIENDLY VISITING

Friendly visiting to chronic patients selected by the professional staff may also be done by volunteers. Some organizations have found visits to shut-ins and chronics by volunteers who drop in occasionally to read aloud, to teach some type of hand work, or generally to act as friendly visitors, very much appreciated. The selection of the visitor is important because personality plays an important part in a successful visit. The visitor should be introduced to the home by a nurse and should never make a visit without calling the office first and reporting afterward.

HOME VISITING

Experienced volunteers may also be used in doing some types of follow-up work for clinics. This would be considered an "advanced" job, calling on a mother who has not been back with her child, checking addresses, delivering messages when the patient has no telephone and cannot read. One organization has a volunteer assigned to each nurse for certain days, the nurse using her to make such visits which, of course, do not include any nursing care or health teaching.

GROUP VOLUNTEER SERVICE

Making supplies and keeping the loan closet is almost always done by a volunteer group. Here is a real opportunity to ask a club or church group to take complete charge of the making of supplies; collecting material, etc., for the loan closet.

Another type of group volunteer service is the collection and preparation of a circulating library for the shut-in group. The local public library will help to arrange an extension service. This is a type of service endorsed by the Hospital Library Committee of the American Library Association and the American Hospital Association and offers great possibilities.

SOME DO'S AND DON'TS FOR EXECUTIVES

Don't keep volunteers waiting. Do have tasks planned and ready before letting them come, and have some special person responsible for explaining the tasks, or a multigraphed manual of directions to prevent misunderstandings.

Do give the volunteer enough responsibility so that she feels she has a vital part to play in the program of the organization.

Don't say you want volunteers if you begrudge the time they require. Do give them, if you let them come, the same sort of interest, supervision, and thought as you give the professional staff.

Don't expect a volunteer to be interested in dull jobs unless she is shown the value of them. Do show her the connection between her part and the whole.

SOME DO'S AND DON'TS FOR VOLUNTEERS

Don't start in unless you are serious in your plan to give service.

Don't be afraid to study and find out all about your job in every way you can. The more time you give to this the more you will enjoy your work.

Don't be irregular and unreliable.

Don't ever think the service is all one way. If you do it right, you will get far more out of your work than you can possibly put into it.

Lay Participation in Public Health Work*

By KATE H. TRAWICK

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THROUGH private initiative and individual effort, we have had services in the fields of education, welfare, and health for hundreds of years. The first organized groups were connected directly or indirectly with the church as orders or sisterhoods. As a function of government, the education of the people is not more than a hundred years old in the United States—in fact not that old in the southern states, which undertook programs of public education just before or soon after the Civil War.

Public health service is of yet more recent development than public education. Its beginnings sprang from fear in time of epidemics. Its emphasis has been extended from sanitation and segregation to prevention and protection, from disease to health.

It is easy to see how volunteer workers must have been used long ago, when the nurse saw need and poverty in the squalid, insanitary homes. She must have asked her friends for clean garments for the patient, and clean linen for the bed, as well as for food and medicine.

The transition from the visiting nurse giving bedside care only, to the public health nurse as we know her was the logical development of the nurses' part in a planned and official program of health protection. Florence Nightingale's teaching furnished the pivot on which the swing of emphasis was begun. She insisted that nurses should be able to teach the rules of sanitation and hygiene, and she was the first person on record to advocate the doctrine of "generalized nursing service." She spoke of "health nursing" over and over, at a time when preventive nursing was otherwise unheralded.

The twentieth century showed a great increase in the number and kind of voluntary organizations interested in the control and prevention of disease. The growth of private, or volunteer agencies, stimulated the development of the health programs of the official agencies. It has always seemed to me that we need both private organizations and public agencies—but that coöperation is the keynote of all good public health work. No group, working alone, can do much towards changing conditions. We need to remember that there are several groups of people interested in public health activities. There are the professional groups of workers—including doctors, nurses, educators, sanitary engineers, laboratory workers, and technicians; the volunteer or lay groups of board and committee members, with whom the professional groups work; that part of the public for whom they work; and the remainder of the general public, indifferent, or critical, or friendly as circumstance or opportunity may determine. Public health programs achieve their best results only when the four groups come together in recognition of their common interests.

BOARD AND COMMITTEE MEMBERS

When voluntary nursing associations came into existence, they were dependent upon local groups or boards for support and interpretation. The functions of these first boards varied, but usually included defining the field, approving policies, raising budgets, securing publicity, and interpreting programs. I have heard more than one executive say that another function of board members was to furnish the appropriate scenery of wealth, social position, and prestige, and I have heard board members sigh for a chance at something besides raising money; to

*Presented at the luncheon meeting of Board and Committee Members, National Organization for Public Health Nursing, Biennial Convention, Washington, D. C., April 23, 1934.

have some real part in formulating plans and policies; to do something more than rubber-stamp the program of the executive-secretary, or director. The day is past, we hope, when board members are expected to be happy when limited to supplying scenery, or raising money. Have you ever heard it said that the only thing wanted of a certain woman was the use of her name? It would be a good thing if we could abandon that policy, even in magazine advertising. Any intelligent, capable woman resents being made a figure-head or a rubber-stamp.

The other side of this question is not without its problems, for the professional group who must work with the volunteers have their difficult moments. This is always true when the division of labor is such that the board and committee members have all the authority, and the professional workers all the responsibility. Opportunities for misunderstanding and friction are especially plentiful in health work where a member of the volunteer group may step innocently and ignorantly over the hedge and into the field of professional ethics. The board and committee members of a health agency or organization need special education in the delicate and complicated subject of professional relationships. The opportunities for misunderstanding spring too readily to mind: Enthusiasts for public health may be easily accused of advocating state medicine; a board member may be told that a public health nurse has been guilty of diagnosing and prescribing—because of differences in procedure in different states, or in different sections of the same state; medical societies may hold to different rulings on apparently simple matters; public health nurses do certain things in some countries or states as a matter of routine that they are not permitted to do in other places and a practice that is considered ethical by one medical society may be anathema to another. Where members of the professional groups themselves do not agree, how can the non-professional worker, board or committee member know where tradition leaves off and common sense begins?

The National Organization for Public Health Nursing has gone about the education of lay workers in such a systematic and comprehensive manner in the last few years, that we can scarcely think back to the days bounded by scenery and finance. The outlines for the training of board and committee members not only suggest what the members should know, but tell them how and where to secure the information, and how to use it. Health surveys, conditions, needs, machinery, organizations and programs, institutions, and personnel, legal requirements, relationships, services, statistics and budgets, are studied in carefully planned courses. Realizing that action without thought is perilous, and thought without action is futile, the courses of study are accompanied by a program of things to do, such as aiding in clinics, making supplies, being friendly visitors, helping with transportation, with records, with office work—with a regular schedule of hours and days. By using outlines prepared for the purpose, board and committee members can also make a fair appraisal of the value of their services.

COUNTY HEALTH COMMITTEES IN TENNESSEE

Following a less elaborate, but a fairly practical plan, we have been trying for a number of years to increase our groups of county and local health committees in our rural health work in Tennessee. Health committees are at work in most of the forty counties with full-time public health units. These committees may function as part of an organized group such as a Parent-Teacher Association, a federated or community club, or as independent committees interested in a particular school. We find it practical to develop the program with the school as a center—for the school serves many purposes in a rural area. The form of local committee organization is simple, the program flexible, easily adapted to local conditions. The plan has been in use for about ten years, and calls for sub-committees on publicity, investigation, loan closet supplies and relief, school and health conferences, and transportation. Local health committees

are, or expect to be, part of a county-wide health council. In a county which I visited recently, one committee member had been instrumental in organizing forty local health committees. This is a rural county with 50,000 people, with enough public health nurses to keep in touch with the committees, to see that they do not become discouraged. We have learned that the program must be definite and continuous, with emphasis on seasonal activities. This is most necessary in rural health work where bad roads and bad weather can play havoc with the best laid plans. Well-baby and preschool conferences have summer emphasis, the general immunization program when the crops have been laid by, school examinations and corrections during the school term, while we have a few all-the-year standbys, such as tuberculosis case-finding service, maternity and infancy work, and sanitation.

Recently, we have found a trend toward specialized nursing service brought about by C.W.A., C.W.S., F.E.R.A., and other emergency set-ups, which have not been coördinated with the regular agencies, and we are finding an increase in overlapping and duplication in nursing service. An extreme example of what such a set-up does, is this: A busy mother is trying to get her Monday washing on the line. Her first interruption comes from the city nurse who has the mother on her list of prenatal cases. This is a lengthy call from a new nurse. The second visitor is working under one of the alphabetical administrations and wants to know about the hospitalization of the five-year-old boy crippled from infantile paralysis. At about 11:00 o'clock a nurse working in the school program of the C.W.S. comes to ask why ten-year-old Mary did not keep her engagement at the dental clinic the Saturday before. And just at noon, the tuberculosis county nurse calls to see if the children can be tuberculin tested before the next tuberculosis clinic to be held the following week. The finishing touch is given in the afternoon by the insurance company nurse who calls to check up and report on the insured father, he having lately returned from the county sanitarium. The mother decides then and there that there can be too much of a good thing as attention to health, if it offers such difficulties to a cleanliness campaign.

We had grown to think that such happenings as this were beyond the realm of possibility but they are not as exceptional as we hope they will become. How may they be prevented? By an extension of the organization of lay groups which shall bring all the public health nursing services into a program of coöperation and coördination. All social work has been going through a time of tremendous strain, under the necessity of caring for groups and needs for which it has had neither programs nor machinery. At present the danger of duplication is less in rural than in urban sections. Efforts in rural communities cannot be so intensive because population is spread out and inaccessible. In theory, it should be as easy to do public health work in the country as it is in town. In reality, it is much more difficult, because by all the conditions of his life and being, the farmer is an individualist, and the problem more diffuse. The more rural the community, the less the people are influenced by what other people think or do, and the slower, the greater and more persuasive must be the personal appeal. Each individual seems to think, behave, and act on his own initiative. Here we find an added reason for the need of lay groups in rural work. They can influence public opinion, and make it possible for the trained workers to carry on a program.

Another point made clear by the rural picture is the necessity for generalized nursing service. There may be argument for specialization in cities but it is plainly not practical for the country. Time, distance, and expense make it imperative for one nurse to do the various types of work within a given district. Of the 3,000 counties in the United States, only about 525 have full-time public health units. Of this number, only fourteen appropriate as much as $1.00 per capita for health services. The public health personnel, especially in the nursing service, is as inadequate in every state as is the budget.

The voluntary agency has an important place in the field of public health. Some of its functions are the creation of official agencies; the promotion of activities of the official agency; education of the public in its program and services; development of adequate support for the official agency; study of program and budgets to prevent waste of funds and curtailment of needed services. It should bring into coöperative relationship the organizations, agencies, and services available to meet the health needs of the community or county. Because much of its work deals with unseen values, it is difficult, but increasingly important, at a time when economic conditions put added emphasis on building houses, bridges and highways, hewing wood and drawing water in order to give employment, that the voluntary agency be an active watch dog to see that the public cupboard is not bare of the bones that are needed to keep alive the departments of education and of public health. Until we have a balanced health program, with adequate medical, dental, and hospital facilities, and full-time public health protection for all the people, rural and urban, with adequate financial support, we shall have almost unlimited opportunities for the coöperation of board and committee members, and for lay organizations.

ESSENTIALS OF GOOD PUBLIC HEALTH NURSING SERVICE

How the Indiana State Advisory Nurses judge a community E.R.A. nursing service:

1. Active, strong and representative lay advisory committee.
2. Active medical advisory committee.
3. Clear understanding on part of committee and nurse of their respective responsibilities.
4. Regular and profitable committee meetings.
5. Annual budget—including estimated expenditures, expected income and plan for raising additional revenue where needed.
6. Adequately equipped and maintained office outside nurse's home.
7. Sound program (based on survey of needs) looking toward future.
8. Definite policies in accord with the principles of public health nursing.
9. Definite plan of work.
10. Satisfactory relations with health authorities.
11. Satisfactory relations with school authorities.
12. Satisfactory relations with local medical society.
13. Standing orders for all phases of service from medical society.
14. Careful techniques.
15. Scrupulous observation of ethics.
16. Articulation of nursing service with other health and social agencies.
17. Businesslike handling of reports, records and funds.
18. Adequate and well-kept bag and equipment.
19. Adequate transportation—available so nurse can plan ahead and carry out program as planned.
20. Adequate publicity.
21. Good working and living conditions for nurse.

—*Indiana Monthly Bulletin, Division of Public Health.*

Preventing Blindness Through Care of the New Baby and Young Child

By MARY E. STEBBINS

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TRUE prevention of any condition, physical, mental, social, involves eradication of the underlying cause, however remote. Prevention of blindness is no exception and yields unusually high dividends when known scientific facts are applied to the lives of human beings. It is estimated that from seventy-five to ninety per cent of all blindness could be prevented if this application were made.

No one part of an organism can be expected to be sturdier than that organism as a whole. The eye is certainly a part of the body and yet it is more than usual to encounter a total absence of consideration of the eye in any relation whatsoever to the rest of the human body. The erroneous idea persists that if one of the senses is impaired, the compensation for that impairment will be experienced in additional strengthening of other functions. What is more apt to happen is that the condition which impairs one part of the body will impair others. It is therefore necessary to think of the eyes of a person in relation to that entire physical body and to remember that while each part of that body is subject to its individual difficulties according to its location, construction, and function, still, what benefits the whole will be reflected in benefit to its component parts. The eyes suffer from constitutional disorders and benefit from their improvement, much more than the majority of people know or think.

PROVIDE CARE OF THE EYES OF THE NEW BABY

Care of the eyes of the new baby is one of the important means of preserving eyesight; to be most effectual that care must be interpreted in its true sense and include the baby's prenatal life reached through care of the mother in the very early stages of pregnancy.

Hereditary Blindness: Nearly a quarter of all blindness is hereditary, it is estimated, and the laws of inheritance have been traced of such eye diseases as high myopia, retinitis, pigmentosa, optic nerve atrophy, congenital cataracts, glaucoma, and others.* Blind persons should not contemplate having children without medical sanction.

A disease recognized as the cause of much blindness and many cases of seriously impaired vision is syphilis, much of which is hereditary.** This can be rendered harmless and the baby protected from many potential tragedies, not the least of which is blindness, when the prenatal mother is given proper treatment.† "Syphilis, in the latent stage, as it exists in most pregnant women is difficult to detect. This means that it must be suspected in every case, for a successful termination of pregnancy and a healthy child cannot be expected in the presence of an active or even a quiescent infection of this nature. . . . The results obtained by the early treatment of the syphilitic mother are scarcely paralleled in other medical conditions. An infected offspring is

*Bickerton, J. Myles, M.A., F.R.C.S., "The Menace of Hereditary Blindness," *British Medical Journal*, January 20, 1934.

**The American Social Hygiene Association, 50 West 50th Street, New York, N. Y., is sponsoring a campaign for conquering congenital syphilis. Information may be secured from this address.

†Ingraham, Norman R., Jr., M.D., Kah'er, James E., M.D., "The Diagnosis and Treatment of Syphilis Complicating Pregnancy," *American Journal of Obstetrics and Gynecology*, January, 1934.

seldom encountered if therapy has been commenced prior to the fourth month of pregnancy."

Eye difficulties due to hereditary syphilis do not always manifest themselves immediately after the birth of the baby. Certain lesions which occur between the ages of four and sixteen years are frequently of prenatal syphilitic origin. The competent ophthalmologist will exhaust all diagnostic tests before abandoning that supposition. The hope for saving the vision lies in persistent constitutional treatment. Immediate results of such treatment in improved vision are often so satisfactory as to beget carelessness on the part of the patient or of adults responsible for a child. When treatment is discontinued too early, recrudescence will occur. One of the difficulties confronting nurses and eye social service workers is that of persuading these patients to continue under treatment for the required long periods under the ophthalmologist's direction. With adequate treatment the hope for the retention of some vision is justifiable.

Ophthalmia Neonatorum: The need for correct treatment of the eyes of the new-born baby continues. Ophthalmia neonatorum, commonly known as "baby's sore eyes," once one of the devastating menaces to eyes and vision, has been rapidly reduced since the acceptance of Dr. Credé's exposition of the effect of the instillation of one per cent nitrate of silver into the eyes of new-born babies. Failure to utilize this knowledge is unjustifiable whether or not the use of nitrate of silver is required by law; one per cent nitrate of silver is the one sure prophylactic in all cases and can do no harm in any case. Many official health agencies furnish ampules of nitrate of silver free to practicing physicians and midwives.

Nitrate of silver one per cent, one or two drops in each eye, must be used immediately after the birth of the baby, the baby's eyelids, face and hands having first been cleansed. The omission of the baby's hands in this cleansing may be regretted. It is futile to protect the baby's eyes with drops only to have them reinfected by being rubbed with the baby's own, small, unwashed fists as is a custom with babies.

Any redness of eyes or lids, any discharge, should be immediately reported to the physician in charge. Delay may prove really serious.

A five-year study recently completed and reported in March, 1934, disclosed that within that period in New York State, exclusive of New York City, nineteen babies lost their sight and sixteen others have seriously impaired vision for life because of ophthalmia neonatorum.* It is feared that similar studies in other states might reveal equally or more serious figures. In the light of present-day knowledge, such evidence of neglect is difficult to explain or excuse.

Education seems still to be needed; education of physicians, hospital authorities and the lay public, to the importance of the invariable use of nitrate of silver in the eyes of all new-born babies. Some of the objections to its use might be effaced if the emphasis was placed on having these drops used in the eyes of every baby, and all suspicion of discrimination in certain cases or because of special reasons eliminated, then no needy cases would be inadvertently missed. When the custom becomes universal, blindness from this cause can, as it should, be wiped out.

Care of Healthy Eyes: After the first treatment of the baby's eyes nothing further is done unless suggested by the doctor. Healthy eyes do not need treatment. This is true of the young baby as of other persons. The lids of the closed eyes will be washed when the baby's face is washed; nothing need be put into the eyes. Tears—the best eye-wash—are constantly bathing the eyes whether or not one is crying.

Sunshine and the Baby's Eyes: Sun baths, properly managed, have become routine for most babies. Mothers are sometimes concerned about the possible effect of sunlight on the baby's eyes. Ophthalmologists and pediatricians agree that no baby's eyes have been permanently damaged during sun baths.

**Sight Saving Review,* June, 1934, p. 136.

The same precautions should be taken to protect the skin of the face and eyelids as of the rest of the body. "It would probably be wise for the first month of life to protect the eyes and eye tissues from any considerable exposure to the sun. The carriage hood suffices. . . . Usually by the time the physician orders sun baths, the only precaution necessary is to have the child's feet directed away from the sun. Lying in this position mornings and afternoons the summer sun baths are given, the sun's rays strike the top of the baby's head and forehead, the overhanging brows and eyelids," and do not penetrate the eye.*

Provide Adequate Diet: Diet plays its own rôle in building strong eyes and in protecting them from disaster; adequate diet throughout the prenatal period of the baby's development and continuing through life. A diet which contains sufficient quantities of the essential elements of food will protect against the development of certain types of eye diseases; when added to a deficiency diet will effect their cure and aid materially in improvement in other types.

One of the many dangers lurking in the long-continued depression with its accompanying reduced food budget in large numbers of families, is the possibility of many cases of eye and vision disturbances in the years to come.

TRAIN THE YOUNG CHILD

To Protect His Eyes: Eyes are particularly susceptible to transference of infections which are so easily carried on articles of personal use. Continued and vigorous emphasis still needs to be placed on the menace of the common towel in the home and in public places. Sound, early training of the young child in the use of his exclusively own handkerchief, pillow case, wash cloth, towel, table napkin, will protect him from this particular danger, as will the training to wash his hands after going to toilet, and to avoid rubbing his eyes.

In the Right Use of His Eyes: As soon as a child reaches the pencil-and-paper or picture-book stage his training can be begun in the position in which he should hold his body in relation to the book and to the light. Simple equipment, as a slanting desk or table, will facilitate his early efforts. A tendency to bend the face down over the pictures when sitting, or to lie face down on the floor with the eyes above them, is to be decried and persistently combated.

Books of sufficiently large sized type printed on non-glossy paper should be used for children, and work and play suited to their age.

Light should fall over the left shoulder from the rear for the right-handed person; not directly from the left nor from the left front as so often happens; certainly not directly in the face from the front. For the left-handed person the rule is reversed, the light to fall on the book from the right and the rear of the individual.

In Protection Against Eye Injuries: Protection of the eyes of babies and young children from accidental eye injuries is inevitably the responsibility of adults. Home and furnishings can be free of projecting pointed objects against which a toddler may fall; toys and playthings can be selected that hold no potential dangers to eyes. No young child should be permitted to have sharp pointed scissors, pointed pencils, knives, or other objects which can so easily puncture an eye.

Contrary to common belief, much danger lurks in cap pistols, wooden swords, arrows, and similar weapons; scores of eye accidents have been caused by them. Young children should not handle even the simplest of fireworks, as sparklers and torpedos; adults should see that children are at a safe distance when fireworks are being discharged. A three-year-old girl struck in the eye by flying gravel from an exploding torpedo, developed a cataract.

Any eye injury deserves prompt attention from a competent eye physician. Punctured wounds are especially dangerous both for the injured eye and be-

*Reprint No. 30, "Protecting Baby's Eyes During His Sun Bath," National Society for the Prevention of Blindness, 50 West 50th Street, New York City.

cause of the possibility of sympathetic ophthalmia developing in the uninjured eye, unless proper treatment is administered to the injured one. "A scleral wound, either operative or accidental, seems definitely to favor the development of detached retina, a vitreous exudate, or both,"* either of which is destructive to vision.

REFRACTIVE ERRORS

Refractive errors in young children are far from uncommon; unless discovered and properly cared for, impaired vision of greater or less severity may result. Vision testing of children of no more than four years of age has been successfully done and is one of the protective procedures which can be advantageously extended to all preschool children, not waiting until school entrance age has been attained.

The prejudice of adults against the wearing of glasses by children who need them, is unjustifiable. Children themselves, wise enough to recognize the ease and comfort the glasses furnish, do not as a rule and of their own initiative, object to wearing them. Instances are known where quite young children, less than two years old, have consistently cried when the glasses were removed and have as consistently become quiet when they were replaced.

Another adult fallacy is that there is danger of the child's breaking his glasses, possibly injuring the eye with the broken glass. Young children, it seems, do not break their glasses any more frequently than the average adult, while the glasses are an additional protection from flying objects.

An ideal program for conservation of vision would include periodic vision testing for all children, beginning no later than four years of age, followed by corrective attention where indicated.

Crossed Eyes: Squint or crossed eyes is a correctible condition too generally thought of as of minor importance. In reality, vision diminishes fairly rapidly in the crossed eye and blindness in that eye may usually be expected unless remedial measures are instituted early. Delay is disastrous. No one outgrows crossed eyes as is so often stated by misinformed persons whose advice is accepted to the everlasting detriment of some young, helpless child.

The crossed eye should be put under expert care at the first moment that any deviation from a normal position is detected. Begun thus early corrections and consequent preservation of vision are generally accomplished. Glasses, which are to be worn during all waking hours, and eye exercises under the direction of the ophthalmologist, constitute the usual treatment. The eye exercise frequently consists of covering the unaffected eye for stipulated daily periods, forcing the use of the deviating eye, strengthening the weak muscles which permit the eye to turn. A more elaborate system of eye exercises may be instituted.

Ophthalmologists tell us that any baby sixteen months old can successfully wear glasses. Dr. W. B. Weidler says: "I have prescribed glasses for children under twelve months of age and they are worn just as readily by the child as any article of clothing."** Bobbie C., living in one of the counties of the Ozark Mountains of Missouri, was fitted with glasses for a beginning deviation of one eye when he was eighteen months old. No protest whatever was voiced by the child; when the cover was placed over his unaffected eye for the first time, he did not even interrupt his play nor has he during the year he has been under treatment—another evidence that babies and young children are amenable if adults permit them to be. No breakage difficulties have been experienced with Bobbie's glasses. His mother states: "He has never broken his glasses. He takes them as a matter of course and I don't have half as much trouble with them as I do making him keep his clothes on."

If treatment is not begun sufficiently

*Duggan, Walter F., M.D., "Visual Results in Cases of Intra-Ocular Foreign Body," *Archives of Ophthalmology*, December, 1933.

**Publication 119, "What to Do for Cross-Eyes," National Society for the Prevention of Blindness, 50 West 50th Street, New York City.

early and the eye does not become straight under treatment, operation may be recommended. It is a serious injustice to the individual to look upon this operation as simply of cosmetic value. Psychologically it is in many cases of the greatest importance to the person involved. Lives have been made miserable by teasing. Because of this tormenting children have come to shun their playmates, thus missing all the social advantages of group activities, and to avoid adults; have practiced truancy during school years, have grown up to be social misfits, sometimes finding their way into juvenile or adult courts, as social misfits have a way of doing.

Since we are told that every case of ordinary crossed eyes can be cured, why let such a condition persist to the detriment of eyesight and possibly to the whole life of a human being?

REMOVE FOCI OF INFECTION

Eyes, as other body organs, suffer from absorption from foci of infection. When such foci are located in the nearby area—teeth, tonsils, or sinuses—they are especially dangerous to eyes. Removal of such foci, long recognized as of importance in protecting hearts, kidneys, and other vital organs, is of equal importance in protecting eyes from possible inflammatory processes especially of the iris, the ciliary bodies, and the choroid, inflammation of any of which will impair vision to a greater or less degree, perhaps destroy it entirely.

CONTROL ACUTE COMMUNICABLE DISEASES

It is known that long-time as well as immediately undesirable conditions may develop as the result of the acute communicable diseases of young childhood. Eyes and vision suffer from certain types of diseases of kidneys, lungs, and other vital organs which are traceable to early cases of scarlet fever, diphtheria, measles, and other such sicknesses. It is not uncommon that the eye examination, inspired by some visual difficulty, reveals a diseased kidney or other condition of which the patient had no previous knowledge. Improvement in the eye condition will be dependent upon treatment of this underlying cause.

Previously it was considered necessary to darken the room of measles patients, even to blindfold the eyes or to wear dark glasses. This is no longer considered good or even safe practice—the room needing as much sunshine and fresh air as possible to supply ideal recovery conditions. The patient's bed should be placed with the head toward the window. If the light is still too strong for comfort a dark folding screen can be placed around the head of the bed or the child may wear an eye shade. The same arrangements can be made with relation to artificial light.*

More adequate control of the contagious diseases of childhood will accompany improved sanitation and the actual practice of personal hygiene by adults. The very little child being essentially imitative is trained in good or less desirable habits through doing that which he sees done by those about him, particularly in his home. Clean hands, use of individual towels, handkerchiefs, spoons, forks, cups, covered coughs and sneezes, are not habitual with all adults. Until they are, children will continue to contract devastating diseases, entailing immediate and future hazards.

PUBLIC HEALTH SAVES EYES

Every part of a complete public health and social welfare program influences individual and collective opportunities for promoting the health of the eye and protecting it from disease. A widespread educational program is needed for the dissemination of information relative to eyes, their use and care throughout life and the protection of vision. Too much emphasis cannot be put on the care of the new baby and young child. If this period when life's foundations are being laid is sound and safe, a useful, happy, satisfying life may be expected, with broad social and mental, as well as physical, vision.

*The National Society for the Prevention of Blindness, "Care of the Child's Eyes in Case of Measles," 50 West 50th Street, New York City.

Public Relations in Public Health Nursing*

By VIOLET H. HODGSON, R.N.

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ALL individual and communal life is sharing the effects of a changing social order. Institutions which have served, in varying degrees of satisfaction, the needs of society in the old order have been obliged to make adjustments in content or administration of their programs. This is strikingly illustrated in industry where individual and independent control is giving way to coöperative planning with greater emphasis laid on the needs and welfare of the worker and the public at large. It has been demonstrated that the security and well-being of the few depend upon the degree to which this state prevails among the many. We have learned through tragic experience that "no man can live unto himself."

Although industry provides an outstanding example of the shift from individual to group interest, a similar change is apparent in nursing. It is no longer possible for private duty, institutional, and public health nursing to function satisfactorily as independent units. The interest shown and action taken by nurses in solving the problem of overproduction is still further evidence of a trend toward greater coöperative effort. Commendable indeed are these and similar developments in the nursing field. They by no means represent the total picture, and of themselves would indicate but an expansion of individualism within the profession. Everywhere in the background is the public—the *raison d'etre* for the very existence of the profession. To modify, quantitatively or qualitatively, a program of nurse production and utilization without a simultaneous study of the market for service is to ignore the experience of other producer-consumer fields and to continue blindly on the path of increasing chaos.

STUDY OUR MARKET

All too long has nursing emphasized the professional aspects of its development without a corresponding study of the needs and desires of the consumer. It cannot be denied that public health nursing has led the way in recognizing the community as its field for service. In too many instances, however, this has been largely a "lip service" to a portion of the community. Part of the community has been served intensively, while a much larger portion remained uncovered. Insofar as the members of boards and committees have been chosen from a cross section of community interests, the service may be said to be representative. How actively they have been represented is another matter. "Nominal" representation does not make the service a community activity, any more than does service to a limited group. In short, the day of the public has arrived, and public health nursing would do well to lay greater emphasis on this approach to a solution of its problems.

It is not the intent of this paper to review the familiar relationships of the public health nurse to the board, medical profession, social and relief agencies, clinics, hospitals, school, industry, and all the other allied community services. It is rather an attempt to go back of these relationships and search for those factors of larger scope, upon which those principles are established and which tend to make health nursing a true public service. Here again we find that business and industry have led the way through pioneering in the field of "Public Relations."

PUBLIC RELATIONS

Exception may be taken to any con-

*Presented at the state conference of health officers and public health nurses at Saratoga Springs, N. Y., June 27, 1934.

tinued reference to a field—industry—that produces goods and not services. It may also be claimed that the products of industry and public health nursing are not comparable because they do not lend themselves in equal degree to the same yardsticks of measurement and evaluation. It must not be forgotten, however, that goods, like nursing, cannot in and of themselves create a market over and above the demand resulting from a recognized need. Beyond that, "sales" are increased and "customers" retained largely by the standard of performance maintained in the statistically unmeasurable field of Public Relations.

Public Relations has been defined as "the subtle art of analyzing and determining, and the business science of directing the conduct of a group of people within an organization so as to cultivate a friendly and trading response from the public." To quote further from a commercial field: "Public Relations determine and control the policies of a corporation in its dealing with its customers and the public. Rightly conceived and executed, they should cultivate and cement friendly relations between the institution and its clients and prospective customers, thus paving the way for a greater demand for goods or services." Public Relations also takes cognizance of the fact that "the corporation's most vital relationship is with the public. Its success depends on a correct interpretation of the public's needs and viewpoints as well as on the public's understanding of the motives that actuate the corporation in everything it does."

THE NEEDS OF THE COMMUNITY

Progress has been made in the public health field in setting up yardsticks of performance based upon the estimated needs of the community as embodied in appraisal form of the American Public Health Association and similar standards of evaluation. Studies have been made which indicate the approximate amount of sickness in the community at any given time, and current statistical data are available of deaths and reportable illness upon which it is possible to determine the amount of nursing service required to cover adequately the community needs, provided they are fully recognized and provision made for meeting the potential demand. (Here alone we have a vast uncovered field to which our efforts could profitably be directed in solving, to a considerable degree, the present problem of unemployment.) So much for the public *need*.

THE DESIRES OF THE PUBLIC

Have we ever, on the other hand, approached the field from the viewpoint of the consumer and found out with equal exactness what the public *wants?* For example:

Would they prefer more concrete and less abstract teaching?

How many cases of illness are there in families who cannot afford and do not need the full-time services of a nurse, but who would welcome part-time care on a pay basis?

Do families really prefer to have the nurse give prenatal and postpartum care, leaving the responsibility for nursing care during delivery to the family or neighbor?

Would the public always choose a practical nurse who combines a measure of simple nursing care (not always so "simple") with household duties in preference to a trained housekeeper who could give the necessary nursing care under the supervision of a public health nurse?

How many families would welcome the services of the nurse in giving bedside care to a scarlet fever patient instead of assuming responsibility for a type of case that the student nurse is permitted to attend only in the last year of her training?

Are the patients always "thrilled" after the experience of being regimented through a clinic in a military fashion?

To what extent would patients appreciate a little more evidence of "the art of human relations" in the venereal disease clinic?

Do the so-called "problem" families really want or always profit by unduly prolonged and intensive follow-up?

How many times is the patient's point of view the only reasonable course to follow, in spite of its variance with the well constructed plan which the nurse may offer?

These and a host of other public wants might conceivably be weighed, not merely in the hope of strengthening the relationship of public health nursing with the public, but as a means of revealing vast uncovered fields in which a demand for service could be created on the coöperative basis of nursing supply and public demand.

KEEPING THE PUBLIC INFORMED

If it is important for the public health nursing organization to analyze the needs and discover the desires of the public, it is equally essential that the public understand the objectives, policies, and needs of the organization. This necessitates a broad program of publicity that will keep the public in touch with the program the year round and not merely during the annual drive for funds. Goodwill must be established and maintained through a high quality of service and a general approval of the policies and program of the organization. Such approval can be expected only when the public has been taken into the confidence of the organization, and situations frankly revealed which make changes in content or administration necessary. Frequently this knowledge is confined to the board and professional staff. The public, as sole stockholder and consumer, is entitled to periodic reports sufficiently frequent to keep them informed of the activities of the organization.

COURTESY AND FRIENDLINESS

A third powerful factor in cultivating a friendly response from the public is courtesy, to which friendliness is a close relative. It is not flexibility in charges for service or the details of nursing technique that the patient remembers with greatest satisfaction. It is the kindly manner in which each step of the care was given and financial adjustments made. To conduct oneself as guest in every home, no matter how royal or humble, has lasting qualities. To regard each patient at clinic or conference as a guest has "sales" value equal to or excelling that of professional service, however high in quality the latter may be.

ATTITUDE OF VOLUNTEERS

Another important feature of public relations is that of seeing that every person connected with the service typifies the policies and standards of the organization. In this day of increasing use of volunteers, no effort should be spared in their training that will assure the public the same high degree of courteous treatment expected from the professional staff. Oftentimes the volunteer is placed in the strategic position of making the first contact with the patient, and it may be this experience that will determine the patient's lasting reaction to the entire service. Friendliness and genuine interest are basic qualifications for all connected with the organization in whatever capacity.

PUBLIC RELATIONS AND THE DEPRESSION

Finally, many of you may be thinking of the deplorable state from which commerce and industry are now being extricated, and doubts may have arisen as to the part played by a program of Public Relations in bringing them to such low estate. If so, it must be remembered that the aim of Public Relations is to create good will and not to sell. In so doing it smoothes the way between the organization and the customer. Its watchword is courtesy. It does not disturb the balance between production and consumption and should not be confused with "high pressure salesmanship."

It would be difficult, if not impossible, to cite a single instance in which public health nursing suffered during the depression solely because it had secured the goodwill of the public. On the contrary, that may have been the one factor that softened the blow to many a service. Nor can it be held accountable for the uneven development of services in many communities. Here, as in industry, other factors have entered the picture. No—it must be conceded that taking the public into its confidence every step of the way, due respect for the viewpoint of the public, courtesy and friendliness on the part of every one connected with the service, stand side by side with a high quality of service as the refined product that has emerged from these trying years of the depression. This test alone should safeguard to them a prominent place in any program for the future.

Nurse-of-the-Month

HELEN JAMES
New Mexico

Although New Mexico is not my native state I feel extremely proud to have been asked to represent her on this "Nurse-of-the-Month" page. I do have the qualification, if qualification it is, of being a Western girl. I was born and raised on a ranch in Utah; received my college work in Seattle, Washington,

and Colorado Springs, Colorado; nurse's training at the Hospital of the Good Samaritan in Los Angeles; and graduated in public health from the University of California in Berkeley in 1930.

In January, 1931, I was offered a county nursing job in Mora in northern New Mexico. This was a county in a group of sixteen receiving subsidy from the Commonwealth Fund of New York City. This subsidy had been given with the understanding that the counties assisted would assume, year by year, additional financial responsibility for their nursing service. At the end of the year it was decided Mora would not be self-supporting and so Commonwealth subsidy was withdrawn. I was transferred from that beautiful mountainous district which was over ninety per cent Spanish-American, to Eddy, one of our southern counties. Eddy County is a fertile valley region where cotton and alfalfa are raised. It is probably best known for the Carlsbad Caverns and more lately for the potash mines which are being developed into some of the largest of the world.

In September, 1933, I came to Otero County, returning to New Mexico from vacation in California where I had taken the American Red Cross teaching course in Home Hygiene and Care of the Sick at the University of California in Los Angeles. This too is a southern county. It is perhaps best known for the Great White Sands, a gypsum deposit which stretches along the floor of our valley for over 274 square miles, gleaming like a body of water in the distance. Stock-raising is the major industry. Some logging camps are active in the mountains.

For the most part our county is poor, the people depending upon small farms raising fruit, cabbage, and lettuce in marketable quantities when frosts and drought permit. Otero is one of the largest in the state being over 6,500 square miles, the population approximately one and one-half persons per square mile. The distance to the farthest rural school is 110 miles. The roads are not of the best. We have two incorporated towns, four high schools, and twenty rural schools. Some of the school children travel over thirty miles by bus daily, starting before seven in the morning and returning after dark during the winter months.

Our public health program is typical of those throughout the State. We have a generalized program with particular

emphasis on health education as it can be carried on through dental, well-baby, orthopedic, infant, and prenatal clinics; Home Hygiene and Care of Sick classes; inspection of school children and follow-up in the homes; immunization and control of communicable disease. Public health has made strides in our county; certainly it seems to have been so well entrenched with the people that as Commonwealth subsidy is decreased, the burden is assumed someway, somehow by our county.

No little credit for acceptance by the people goes to our active and well organized County Nursing Advisory Committee. Functioning under the joint-committee chairman, a lay person elected with other officers from the Alamogordo or county-seat sub-committee, are sub-committees in the rural communities. To the members of these committees the nurse must bring many of her problems; their solution and the carrying out of her plans lie almost entirely with these committees. This past year the Nursing Advisory Committee members have carried on one or more of the following activities: reporting communicable disease and prenatal cases, investigating homes needing relief, distributing health literature, assisting at clinics, establishing and assuming charge of loan closets, helping with hot lunches at schools, making layettes, and organizing Home Hygiene and Care of Sick classes. The joint-committee assumed the entire responsibility of a house-to-house sanitary survey of the county. The information gained is to be incorporated in a state-wide statistical study. In many of the districts sub-committee meetings are held monthly with the nurse as ex officio member. The joint meetings are held at the county seat quarterly. They are opened with a business meeting and sub-committee reports followed by a program which is of interest to the group.

New Mexico has a state law which requires the protection of school children against smallpox. Early in the school year visits are made to each school and with the coöperation of teachers and superintendents a satisfactory immunization and physical inspection program is carried out. Approximately 2,350 children are enrolled in the schools. All have been vaccinated against smallpox and over seventy-five per cent are protected against diphtheria. Mothers are always urged to bring "preschools" and infants to the school for immunization.

In Otero County we have six physicians, five residing in the two largest towns. Our health officer is a doctor serving in part-time capacity. We have one dentist, and one six-bed private hospital. Laboratory work is sent to the State Public Health Laboratory conducted by the University of New Mexico in Albuquerque. A traveling optometrist visits us once a month.

It is plain to be seen that to maintain clinics for correctional work the children must be carried long distances. For dental correction a day is assigned to each rural school. Parents, teachers, and members of the Nursing Advisory Committee are notified. The children are brought by school bus, truck, or auto for their appointments; sometimes their first trip to the county seat. The distance traveled is often 150 miles return trip, and means a long day for all who have assumed responsibility for the work. The tonsil clinics present a different problem. The hospital at Alamogordo is obviously too small to carry on the clinic work, home operations are slow and often impossible in the small crowded valley "adobe" or mountain shack. Some clinics have been successfully carried on in the school buildings. Each mother is instructed to bring cots, sheets, blankets, pans, and mouth-wipes. A ward is "set up" in one end of the building, a surgery in the other. The doctor usually stays throughout the day. The patients are moved home if nearby or to a friend's late in the afternoon. The nurse plans to stay in the community over night in case of emergency. The children are given a physical examination and blood coagulation test before acceptance in the clinic. So far happy results have been our mete.

I need not say in this land of "Mañaña, mañaña," the nurse practices and preaches, "Ahora, ahora!" I give you Nueva Mexico, la tierra del sol!

Red Cross Itinerant Nurses Lay Foundation for Permanent Program

A COMPOSITE picture of the old-time itinerant preacher would look like the figure in the memorial to Bishop Asbury on Sixteenth Street in Washington—the figure of a tired man, riding a tired horse, with lines slackened from his hands as he rides from post to post to carry his gospel of salvation for the soul to the remote wilds of his pioneer pastorate.

American Red Cross

She can take it

A composite picture of the Red Cross itinerant nurse would show the figure of an energetic, alert woman, in a gray service uniform, with capable hands at the wheel of an automobile, which carries her in a day distances the old circuit riders needed a week to travel. The gospel she preaches is not for the salvation of men's souls, but for the care of bodies, to make them fit temples for the souls of men. And she would be on her way from the upper end of a county, where there is a single case of typhoid fever which the doctors want to check without danger of an epidemic, to a lower boundary line, where a woman is waiting for her fourth baby—the oldest of her family now three years old. On the way she must stop at Jackson's to see the little boy who is reported to have fallen out of a tree and dislocated his elbow. Time must be found somehow for this visit before the car and nurse can call it a day and go back to the boarding house, for dinner and an evening's work at Red Cross reports.

THE DELANO NURSES

The Delano public health nursing service is one of the most colorful and adventurous of the fields open to Red Cross nurses. These nurses are sent to isolated and remote communities, to meet a demand that was obvious to Miss Jane A. Delano, when she was a nurse among miners' families in the sparsely settled regions of Arizona. Because of her interest in the welfare of those in isolated communities she made provision in her will, at her death in 1919, that $25,000 be given to the Red Cross to establish the Delano Nursing Service, named in honor of her parents; this sum is supplemented by the royalties from the sale of her textbooks on home hygiene. The income thus derived is spent for itinerant nursing, through a program which sends a nurse to a community which cannot find, or has not yet wanted to find, money to finance such a service for itself, for a three months' program. The nurse establishes contacts with state and community health officials, with physicians and other nurses, with social service agencies, and in coöperation with them offers bedside nursing where it is needed, carries on immunization campaigns, inspects children, working with school authorities and physicians, and organizes and instructs classes in Home Hygiene and Care of the Sick.

The nurses in this service spend hard days in their three months of pioneering, driving over rough roads into remote parts of their territory to reach houses where cases have been referred to their

care. But their days are well spent. If the work a nurse has started is not taken over by some private or community agency when her term of service ends, it is because the money cannot be provided, not because those she has ministered to fail to realize the value of the project she has initiated.

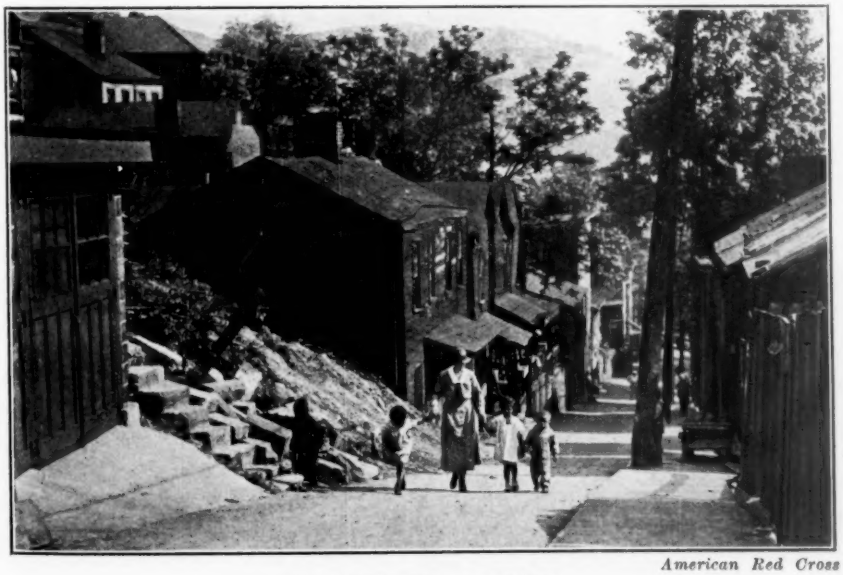
As her classes in home hygiene are carried on throughout her territory a new appreciation is given of the danger of disease, and those who have taken the course are on the alert to report to health authorities any symptoms that might indicate serious illness for an individual or an epidemic for a community. If medical help cannot be reached in a crisis the students have been given instruction which makes them far more skillful than they otherwise would have been. However, because they know physicians and nurses much better than before they took the course they know better how to summon professional help, and we usually find far more friendly relations between doctors and nurses and the people they serve, in the communities where the Delano nursing service of national headquarters and the public health nursing services of the chapters have paved the way for a permanent program for raising standards of public health.

Last year there were Delano nurses in 21 communities, and 43 chapters had itinerant public health nursing projects.

As another winter draws near, all Red Cross nursing services are preparing to continue their program of health conservation, adapting their activities to conform to whatever needs may prove to be the most pressing. The Red Cross has a public health nursing program, through which last year 750 public health nurses were employed by 424 Red Cross chapters. A total of 207,531 cases came under their care, and 1,090,294 visits were made to or in behalf of patients, and 629,025 children were inspected in schools.

WILL ROGERS AND THE SCOTTISH RITE MASONS AID

These nursing activities are carried on through Red Cross chapters, financed by them through their share of the membership dues collected in the annual roll call membership drive. As might be expected, membership receipts are apt to fall off in the communities where unemployment reaches high figures, and many chapters, seeing very clearly the



American Red Cross

"We'll take you to Mother"

need for increased public health nursing facilities, have yet been unable to provide funds for the nurses who are needed. Of decided help in these communities last year were two donations—one by Will Rogers and another by the Supreme Council of the Scottish Rite Masons of the Northern Jurisdiction. Both donations were made with the stipulation that they be spent for the nursing services that were in danger of lapsing because of lack of funds. The contribution of Will Rogers gave partial support to 52 public health nursing services, and 33 other services were similarly aided by the Scottish Rite fund.

American Red Cross

THE HOME HYGIENE COURSES

Since in a period of unemployment there are a good many people who have more time to spend at home than money to pay for service from outside, a number of chapters last year devoted their health activities to the Red Cross courses on Home Hygiene and Care of the Sick. There were 1,426 chapters which secured authorized instructors for courses, through which instruction was given in simple rules of health and the fundamentals of care of the sick in the home.

There were 62,600 students receiving the instruction, and of this number 49,006 completed the course and received certificates showing that they had satisfactorily handled the work. This makes a total of 732,733 who have received these certificates since the Red Cross first undertook this teaching. The federal government endorsed this work last year through coöperation with nurses in the field and in helping to form classes for instruction among those families who were on federal relief. A further endorsement is given in the words of Mrs. Franklin D. Roosevelt, who says, "Every girl should know how to read a clinical thermometer; how to recognize ordinary symptoms of illness . . . how to make a bed with a person in it; how to give a person a bath in bed."

Teacher training courses were held last summer in several universities and colleges. At the University of California in Los Angeles 27 were enrolled; eight took the course in the Colorado Agricultural College at Fort Collins; nine took the training at Pennsylvania State College, and 15 at the University of Syracuse in New York.

What the public health program of the Red Cross can accomplish next year depends on the response given this autumn to the Red Cross membership roll call campaign. Every community which enrolls a good membership total will have for local work a sum which will at least make a beginning in community health work, or continue a program already begun. The Red Cross relies again this year on the interest of nurses and medical workers everywhere for help in the campaign which opens on Armistice Day.

SEX EDUCATION AS APPLIED TO THE CHILD HEALTH SERVICE

FROM THE STAFF OF THE NEW HAVEN (CONN.) VISITING NURSE ASSOCIATION

It will be remembered that the Scranton (Pa.) Visiting Nurse Association, the Saginaw (Mich.) Visiting Nurse Association and the Association for Improving the Condition of the Poor of New York (N. Y.) have all contributed outlines of teaching content in various types of visits (see March, April, May, July, October numbers of this magazine.) The New Haven (Conn.) V.N.A. now adds suggestions for use in presenting matters related to sex—sex education if so formal a term is preferred. Comments will be welcome.

Sex education is not an end in itself. It should always be secondary to nursing care and health teaching, and *should be attempted only when the nurse feels comfortable and at ease with the subject matter* and when it can be woven into the situation as a natural part of the health teaching. It should not be discussed as a separate, isolated entity.

GOALS FOR THE NURSE

I. To equip herself with adequate content to help mothers acquire, when they desire it, sufficient information and methodology to offer to their children sex instruction regarding:

- A. Origin of babies
- B. Process of birth
- C. Coming of another baby
- D. Physical sex differences
- E. Father's part in reproduction, as well as mother's
- F. Organs and functions of the body

II. To demonstrate a matter of fact unemotional attitude toward sex

- A. By recognizing teaching opportunities in:
  - 1. Care of the newborn
    - a. Anatomical information which can easily be imparted:
      - (1) In female babies—explain that the vulva is larger in proportion to rest of body than it will be when baby is older (just as size of head is explained, crookedness of legs, etc.)
      - (2) In male babies—explain that the scrotum changes in size according to body temperature; when the baby is warm the scrotum is soft and larger, but when the baby is cold the scrotum is smaller and harder.
    - b. Vocabulary to be used to give mothers familiarity with terms:
      - (1) Removal of vernix—vulva
      - (2) Care of discharge—vagina
      - (3) Care of cord—naval
      - (4) Care of foreskin—foreskin, penis
      - (5) Circumcision—penis
  - 2. Bath demonstration
    - a. Vocabulary to be taught:
      - (1) Naval
      - (2) Vulva
      - (3) Scrotum
      - (4) Testicle
      - (5) Buttocks
      - (6) Penis
    - b. Children observing learn sex differences: if children are casually interested, it is not necessary for the nurse to offer explanation of procedure, but if child appears intently interested, even if he asks no questions, it is well for the nurse to explain casually what she is doing; e. g., "We wash baby's face first before the water gets soapy and gets in his eyes to make them smart"; "We have to be very careful in washing the naval because it is a tiny place and hard to keep clean";

"Dirt collects here so we take great care that the folds of the scrotum are clean." If the child asks questions, they should be answered carefully but correctly and simply.

3. Taking rectal temperature
   a. Vocabulary to be taught:
      (1) Rectum
   b. If children are present and are at all interested, explain what you are doing and why this way: taking the temperature to see if the baby is sick; if he were larger, you would put the thermometer in his mouth but he is too little and he might bite or break it.
4. Changing diapers
   a. Vocabulary to be taught:
      (1) Vulva
      (2) Scrotum
      (3) Testicle
      (4) Penis
   b. Matter of fact attitude and comment if baby's hands stray to genitals: all parts of the baby's body are the same to him and he is interested in discovering them; however, since handling the genitals is more apt to arouse pleasant physical sensations which might lead to an overemphasis on this part of the body, it is a good idea to bear this in mind and when indicated, before starting to change the diaper, to give him something to hold so that his hands will be occupied.
   c. If children are present, explain that baby has bowel movements and urinates just as older child, only he is too young to go to the toilet by himself, and hence he soils his diapers.

B. By helping mothers recognize teaching opportunities:
   1. Preparing child for coming baby (see pamphlet and references)
   2. When child handles genitals
      a. When diapers are changed: offer something to ho'd before you start; or if hands have already discovered genitals, distract attention by showing a toy or spoon, etc.; let child remove his own hands to grasp object (if you remove the hands it calls the baby's attention to handling his genitals).
      b. When bath is given: interest him in helping with bath; give soap to hold, washcloth to wash face, etc.
      c. When child is playing: without calling attention to auto-erotism, interest him in something else; if child realizes you know what he is doing, you may say in a matter of fact way that it is not a very grown-up thing to do; then distract his interest by suggesting something else for him to do, for example, "Come, it is time for lunch now," "Please open the door for the kitty," "Please help mother fold these clothes"; never punish or scold.
   3. When the cat is to have kittens (or the dog, puppies) explain that the cat is becoming larger and fatter because she is carrying little kittens in her body. All mothers grow large when they carry babies in their bodies before they are born.
   4. When the child sees animals copulating, explain that the father animal is putting his seed in the body of the mother animal so that a little baby animal can grow from the father seed joining a mother seed which is already in the mother's body.
   5. When a friend or neighbor is going to have a baby, if she is in sympathy with the idea, seize the opportunity to tell your child about the coming baby, very much as you would if you were to have the baby (see pamphlet and references).

Again it should be emphasized that the most important factor to keep in mind is that sex teaching should always be so much a part of the natural situation that it is never well done if it is made conspicuous in the child's mind. It should always be as casual and matter of fact to him as any other bits of information he may acquire.

HOW TO PREPARE YOUR CHILD FOR THE COMING BABY

The knowledge that it is a very wise thing to do should make the mother feel very comfortable and easy as she goes about preparing her older child for the coming baby. By far the easiest time to instill a natural attitude toward sex is while children are still infants and toddlers—at this time they learn without realiz-

ing that they are doing so. Their sex knowledge is just a general part of all the information they are acquiring day by day. Any bit of sex teaching should be repeated again and again as opportunity offers so that eventually it becomes a part of the child's understanding without his being especially conscious of it. In this way things are made easy for the child and later he will be saved many of the difficulties that most of us had in growing up.

SUGGESTIONS FOR THE NURSE TO GIVE THE MOTHER

1. No child is too young to be told that a new baby is coming. He needs to be told over and over again. Show him pictures of babies, tell him stories about them, get him used to the idea easily, naturally, and over a long period of time (5 or 6 months) so that the baby will be neither a surprise nor a shock.

2. Tell him again and again how helpless and tiny the new baby will be. Explain that the baby will not be able to feed himself as he can or is learning to; that the baby cannot eat vegetables, eggs, and other foods as he can, but that he will have to live on milk for the first few months, and that he will have to suck the milk from the mother's breast or from a bottle because he cannot drink milk from a cup as he can.

3. Help him to look forward to either a little brother or a little sister. A child is often very disappointed when a little girl comes if he has heard only a little boy talked of, (or vice versa.) Tell him that we cannot tell until the baby is born whether it is a little boy or a little girl.

4. Help him to understand the baby will have to grow a long time before he will be big enough to be a playmate—that at first he will be very tiny and helpless and will need him to help take care of him.

5. Tell your child that the baby is growing inside your body; that he started from a tiny little seed and that he is growing every day. When the baby begins to move and kick, let your child feel your body from time to time to help him understand that the baby is really growing there. Explain that moving and kicking are helping to make the baby strong enough to be born later and live in the outside world as other little children do. If your child asks further questions, answer them honestly and simply.

6. The new baby will take a great deal of your time and attention. Unless your child is made to feel as necessary as the baby, he may be hurt at his place being taken and resort to babyish ways of gaining your attention. Let him plan with you where the baby will sleep. Show him the baby's clothes and tray, and explain how it will be used. Help him to feel that he has a part to play in caring for the new baby.

7. Long before the baby comes encourage your child to do as many things for himself as he can. This will make it easier for him to see you giving so much of your time to the new baby, because he will already have learned to enjoy doing things for himself. It is nice for him to have little tasks that he may learn to take pride in his part in making the home pleasant. He should play by himself so that he may become more resourceful and he should have playmates his own age that he may learn to get along with them.

8. Oftentimes in spite of trying to prepare the child for the coming of the new baby, he will find it hard to have a baby in the home and may show this by trying to hurt or pinch the baby, by displaying temper, wetting the bed, or "showing off," etc.

    a. Punishment should never be used. It occasionally corrects the behavior, but it always makes your child feel that you care more for the new baby than you do for him.

b. Always make your child feel as important to you as the new baby. Because your child really is older than the baby, be sure that you treat him so. It is possible to be impartial without always treating your children the same—certain things are the baby's right; certain other things, the older child's.
c. Help him to accept the baby in the family group by encouraging him to do little things for him.
d. Be careful to encourage other house members, relatives and friends to give your child as much attention after the baby comes as before. Help them to understand that teasing is never wise.

If you are persistent in these things, the undesirable behavior will soon stop.

REFERENCES FOR PARENTS

Child Training
Beginnings of Training—Child Study, 221 West 57th Street, New York City, March, 1933.
Off to a Good Start—Child Study, October, 1933.
The Control of Basic Habits—Parents, 4600 Dwersey Avenue, Chicago, Ill., October, 1933.
Sex Education
The Dangers and Advantages of Sex Instruction for Children—Mental Hygiene, 50 West 50th Street, New York City, July, 1932.
How to Answer Questions on Sex—Parents, May, 1933.
What to Tell Children About Sex—Parents, May, 1931.
Children's Part in Sex Education—Parents, February, 1932.
Preparing Your Child for Marriage—Parents, December, 1930.
The Teaching of Sex to the Young Child—Hygeia, 535 N. Dearborn Avenue, Chicago, Ill., November, 1933.
Sex Education: The School Child—Hygeia, October, 1933.
Sex Education: The Mating Period—Hygeia, January, 1934.
Sex Education: The Anatomy and Physiology of the Reproductive System—Hygeia, September, 1933.
Preparing Older Children for the New Baby
The New Baby in the Home—Child Study, February, 1933.
Preparing the First Baby for the Second—Parents, November, 1929.
Are You Training Your Child to be Happy (page 46)—Publication 202, Children's Bureau.

A CORRECTION

A misleading statement—the origin of which we have not been able to trace—crept into the teaching outline of the Preschool Program, prepared for us by the Visiting Nurse Association of Saginaw, Michigan (published in the July number of this magazine) and has been called to our attention by the supervising dental hygienist in the Department of Public Instruction in Honolulu. At the two- and three-year levels and again in the succeeding age levels, under dentition, the statement is given that the child should have 24 teeth. The deciduous set of teeth numbers, of course, 20, the four additional teeth representing the eruption of the sixth year molars of the permanent set. It is particularly important to point out to mothers that the six-year molars belong to the permanent teeth at whatever age they erupt and that they need special attention. We are grateful to our correspondent for raising this point and are glad to make the correction.—*The Editors.*

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR NOVEMBER, 1934

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, Inc.

Edited by KATHARINE TUCKER

HAIL AND FAREWELL!

It is with very mixed feelings that we announce that Miss Grace M. Coffman has resigned from the N.O.P.H.N. to become Acting Director of Public Health Nursing in the Bureau of Public Health of the State of New Mexico. This exceptionally interesting opportunity—almost a "call"—came at a time when the financial struggles of the N.O.P.H.N. did not make it possible to assure Miss Coffman of permanency with the N.O.P.H.N. Not unmindful of the serious gap in our own staff, we congratulate both Miss Coffman and New Mexico in their combining. The rural, pioneer, and frontier field is Miss Coffman's particular passion and therefore she brings to New Mexico not only exceptional preparation and experience in public health nursing, but an enthusiasm for its particular setting in that State.

GOOD NEWS

The *Survey of Public Health Nursing: Administration and Practice* clearly indicated that one of the most serious problems in the whole public health nursing field is the preparation of personnel. It is a pleasure to announce that the International Health Division of the Rockefeller Foundation has generously loaned an officer of the Division—Miss Elizabeth Tennant—to the N.O.P.H.N. for a year to make certain studies relating to this whole problem of preparation.

Miss Tennant brings to this project an exceptionally pertinent background and experience. Her professional preparation includes the Vassar Training Camp for Nurses; graduation from the School of Nursing of the Philadelphia General Hospital; a public health nursing course at Simmons College; and an industrial hygiene course for public health nurses at the Harvard School of Public Health. In this country her experience includes executive and supervisory service in visiting nursing and school nursing. In 1928 Miss Tennant entered upon her foreign service as a member of the staff of the Rockefeller Foundation. Since then she has spent the greater part of her time in assignments to the several Government schools of nursing or with the related practice fields for public health nursing in those European countries where the International Health Division is coöperating in the establishment of public health nursing education. Every three years the staff members of the International Health Division who are stationed out of this country have a furlough of three months. During these furlough periods Miss Tennant has kept closely in touch with the more progressive nursing developments in the United States.

The N.O.P.H.N., therefore, is exceedingly fortunate in having the loan of Miss Tennant's assistance in studying and taking the next steps necessary in solving the problem of the preparation for the public health nursing field. This project will be carried on under the guidance of the Education Committee.

BEFORE JANUARY FIRST

May we call your attention again to the change in N.O.P.H.N. By-Laws (voted by the members at the Biennial Convention), which raises the requirements for full nurse members after January 1st, 1935, from graduation from a hospital with a daily average of *30* patients, to a daily average of *50* patients. This ruling is not retroactive. Nurses graduating from hospitals with less than a daily average of 50 patients may join the N.O.P.H.N. as associate nurse members after January 1st, 1935, but if you want to be a full nurse member, join before that date.

FIELD SERVICE

Field service this fall is a finely balanced affair between our ever increasing desire to serve the field and answer all possible requests for visits and office commitments of the staff for committees, membership, correspondence, etc., the limitations of our budget, and the ability of the field to pay travel expense and a small share of our $25 per diem charge. Balancing all these considerations, the fall schedule is as follows:

Miss Tucker	
October:	New Jersey, County Advisory Service
	New York, County Lay Institute
Miss Haupt	
October:	Iowa, Field Consuitation Service
	Illinois, State Nurses' Meeting and local community survey
	Rhode Island, State Organization for Public Health Nursing
November:	Massachusetts, State Organization for Public Health Nursing
	Maine, Vermont, New Hampshire, Local advisory service
Miss Deming	
October:	New York, State Organization for Public Health Nursing and scouting for magazine material
Miss Carter	
November:	New Jersey, State School Nurses' Conference
	Connecticut, School Nursing Institute
Miss Davis	
October:	New York, County Lay Institute; Lay Section, State Organization for Public Health Nursing
December:	Florida, Development of local lay groups, State Department of Health

BOARD MEMBERS PAGE

But in this case only half a page to call your attention to five very important articles in this number of the magazine: Medical Relationships, page 573; Dr. Armstrong's paper on the same subject, page 579; Volunteers—An Asset or a Liability, by our own executive secretary, Miss Davis, page 598; Public Relations, by Mrs. Hodgson, page 613; and Mrs. Trawick's comments on lay participation in official health activities, page 604. If you have been considering offering a part-time nursing service to local industries you will find Dr. Evert's report of Philadelphia's experience—page 590—helpful.

Reprints of the project for board members published in our October number are now available free of charge.

We have learned with interest of the increasing number of official nursing services that are developing citizens' committees to support and interpret the program. For instance:

In Indiana no E.R.A. public health nursing service is placed in a community unless there is a lay sponsoring, advisory committee. The State Bureau of Public Health Nursing has prepared a "Packet of Material for Lay Advisory Committees"—one of the best things of its kind that we have seen.

National Leadership Through Individual Membership

SCHOOL  HEALTH

THE MODERN ELSIE SERIES, NO. II

WHEN DOES FIRST AID CEASE TO BE FIRST AID?

"Miss Carling, may I speak to you a minute?" Dr. Landis put his head in Miss Carling's office on his way out, at the close of a busy morning of pupil examinations.

"Certainly, Dr. Landis."

"Last week, Dr. Belcher, over in Norrisville, asked me what we were doing about medical treatments in our school. I told him the usual thing: first aid, cleaning up impetigo and scabies, aspirin gr.V for headaches, etc., and he said his local medical society had registered a complaint against the school doctor for prescribing for an ill child and the school nurse for carrying first aid cases long after they were 'first' aid. There's something in what he claims and I've been wondering just where we stand in the matter."

"When you are not here, Doctor, I follow the set of old routines that I found posted on the first aid cabinet when I came."

"Let's see them—oh, yes, I guess I gave these out originally—well, er—I wonder. For instance, there is nothing here about second dressings or what to do with repeated headaches—or about continued treatments for scabies."

"That's true, and sometimes I am not sure what to do. For scabies, for instance, we give the children the ointment and a note to the parents telling how to use it and the cleaning up routine."

"*Give* the ointment?"

"Yes, to those who can't pay ten cents."

"Then if they come in again in another month and I find scabies, you repeat the process?"

"Yes, Doctor."

"Um . . . If a child has a sore throat and I am not here, what do you do?"

"Isolate him. Take his temperature. Have him gargle with hot salt water and send him home with a note to his parents. The P.T.A. Health Committee offers transportation if the parents can't come for a pupil or I take him home myself."

"That's all right. And then?"

"Then if he is not in school next day and no message comes, I call his mother, either by telephone or I go to see her. If the child is sick in bed and no doctor has seen him, I again urge calling the doctor and I notify the Visiting Nurse Association so that the nurse can go in to give bedside care—that is, if he needs it and his mother wants it. If they can't afford a doctor and the child is too sick to go to clinic, I report a suspicious sore throat to the Board of Health."

"Fine. Well, I can't see anything out of the way in that. Suppose Tom returns next day and still has a sore throat, but has not seen a doctor and I am here, then I see him?"

"Yes, Doctor."

"And I paint his throat with argyrol and send him home again with another note, and report to the Board of Health, is that it?"

"Yes, Doctor."

"Now, if Tom comes in with an infected finger and you give first aid in the shape of a wet boric dressing and tell him to go to his doctor, or the clinic if his parents can't afford a private physician, and he doesn't go, but comes to school next day for a second dressing, then what?"

"Well, of course I put on a fresh dressing and urge the doctor again."

"Could it happen a third time?"

"Well, it might, if the finger was getting better. If not, I'd send him home with a note, and try to see his parents myself."

"You see, these are the types of cases that private physicians question our giving care to—a second dressing on an infected hand, treatment for a sore throat on a second visit—I see their point, but I see ours too. What else can we do about it?"

"Well, we might ask our medical society what to do about it so that our position will be clear to them and forestall their objections."

"Good idea. We'll get *their* standing orders, not mine. Please have some copies of those old orders run off and I'll take them to the Public Relations Committee of the Medical Society for approval."

"Dr. Landis, if you are going to do that, let's review these orders and make them up-to-date—let's add the ones the N.O.P.H.N. recommends and put them all together."

"Fine, and I'll find out from Belcher where he got his standing orders and add any new ones of his. After all, we are not here to hold clinics for the sick, we are here to keep well children well, to teach them how to keep well and prevent epidemics. I don't want you to handle cases of illness nor do I want to prescribe for or treat them. 'Refer,' that's going to be my motto. We are just watch dogs, Miss Carling, we give warning of trouble, but we don't do the shooting ourselves. The more we can teach parents and teachers to be watch dogs too, the less we'll have to do. Personally, I think our work ought to increase the private physician's case load, not take away from it. If parents can't afford a private physician, they can use the clinics in town or follow whatever plan the medical society would like to suggest. The private physicians may want to decide which cases are to be referred to clinics and which he will care for himself if they cannot pay. I'll just see the Principal on my way out to be sure he has no objection to my bringing in the medical society on this. Great idea that—and all yours!"

"Oh, no, Dr. Landis. I must admit not *all* mine. The Visiting Nurse Association asked the medical society for standing orders, that's what put it into my head."

"And it works for them?"

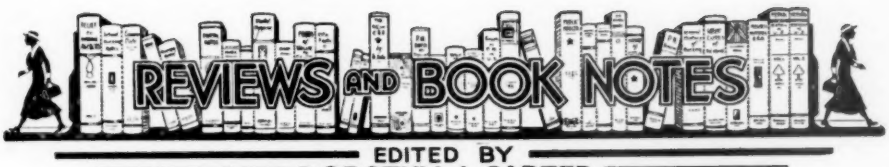
"Like a charm!"

"Fine. Good morning."

"Good morning, Doctor."

The door closed. Miss Carling sat down with a relieved sigh. "Good old Dr. Belcher," she murmured, "I knew if he spoke to Dr. Landis he'd get busy. Now at last we shall have new, safe, ethical, and complete standing orders which every doctor in this town will recognize as fair and will stand back of. I'm one broad smile! Another milestone passed in this school health program."

The next number in the Modern Elsie Series will appear in December, "Miss Carling Steps Out."



EDITED BY
DOROTHY J. CARTER

MENTAL HYGIENE IN THE COMMUNITY

By Clara Bassett. The Macmillan Company, New York. Price $3.50.

Since mental hygiene became of age and extended its field of usefulness to the community as well as to the mental hospital many attempts have been made to show the place it occupies in the community. Some of these attempts have been helpful, but none has succeeded so well as Miss Bassett's in showing the amazing ramifications of the mental hygiene point of view into the philosophies and practices of those community allies of mental hygiene: medicine, social work, law, religion, nursing, and others. The chapter on "Nursing" is but one of twelve in this book, but in many respects the author has made it the most valuable and penetrating of all.

"Probably no other professional group has such a unique opportunity to promote health—mental as well as physical—as the public health nurse." . . . To many nurses this declaration is not new. In one form or another it has been voiced in recent years with increasing frequency. What is new, however, is the clarity and forthright soundness with which Miss Bassett sets about to prove her point. She achieves this, not by quoting dreary statistics anent the frequency of dementia præcox or general paresis as it is encountered by the nurse, but instead by giving us a picture of what illness—any kind of illness—does to the patient; what it means to him in terms of frustrating deeply rooted cravings or ambitions; how it pulls at his submerged desires to regress (through the ministrations of the nurse) to the period of his infancy when everything was done for him and he was taken care of; how his inner conflicts and anxieties often take the visible form of physical symptoms without, however, any adequate discoverable evidences of physical disease to account for them, and so on, *ad infinitum*.

It is the public health nurse whose knowledge of mental hygiene enables her to discover that "a child's persistent vomiting may be due to hearing vivid, reiterated descriptions of similar symptoms enjoyed by its mother at some previous period of her life; or to the tearful nagging, the confusion and haste which invariably accompany the process of getting the child off to school. . . . Five minutes of observation of the helpless pleading, the coaxing and fussing concentration of an emotional mother on the process of forcing her triumphantly resistive child to eat, will often throw more light on a serious case of malnutrition than any number of physical examinations."

Interesting to nurses of all kinds is the author's description of the interrelationships of personalities between the family and patient, and how these often retard or help convalescence, according to the wisdom of their manipulation by the nurse. She also takes up problems peculiar to the experience of the industrial nurse who can apply her mental hygiene knowledge toward a better understanding of the hidden emotional driving forces behind problems of vocational efficiency, shop or store friction and other kinds of industrial maladjustment. Not least valuable in this chapter on "Nursing" is the discussion—with many practical suggestions—of how public health nursing organizations can increase the value of their coöperative relationships with other community agencies, and how the use of a mental hygiene consultant often proves an excellent first step in that direction.

Yet another point brought out in this chapter, a point that has received altogether too little attention, is the matter of the mental health of the nurse herself, and what nursing does to the personali-

ties of many who elect this career. "It is not so clear that the mental hazards of nursing are often severe. The separation from ties of family and home, the necessity for discussing, experiencing and facing problems previously veiled by social taboos, the sudden introduction to the sufferings and hideousness of physical disease, the need for very intimate contacts with and service to all types of people, the possibility of long hours of hard work, of lack of adequate recreation and of severity and rigidity under militaristic discipline, may result in a combination of stresses and strains which overwhelms the relatively immature student and ends in a breakdown, dismissal, or failure. . . . The knowledge and application of mental health principles by teachers, executives and supervisors in nursing schools may result in the prevention of much unhappiness and failure among student nurses and may aid in the process of personality growth and integration."

All in all, this is an exceptionally valuable book and one hopes that every nurse who indulges in any real thinking about her job will keep a copy on her desk. GEORGE K. PRATT, M.D.

MOTHERS' GUIDE WHEN SICKNESS COMES

By Roger H. Dennett, M.D. and Edward T. Wilkes, M.D. Doubleday Doran and Company, Garden City, N. Y. Price $2.50.

This book is intended, the authors state, to help a mother to carry out the doctor's orders, to know when to call a doctor and to recognize communicable disease symptoms. It is especially planned for mothers far from medical aid. It is not intended in any sense to take the place of the doctor.

All nurses know how difficult it is to judge how much a mother can be taught about illness. If her educational background is slight, one tells such and such essential facts, usually things to be done, and shows her how to do them; if she is a deft, well educated woman with scientific study to her credit, one gives her all the information time allows, and demonstrates. But there are so many variations to these two extremes—the nervous mother, the fearful mother, the clumsy mother—that Dr. Dennett's book comes as a welcome help to any nurse planning to make her teaching in disease effective.

It is unfortunate that the authors did not limit their efforts to care of the child in disease—their attempt to cover normal health and habit training is not so successful.

Nowhere in this book has the reviewer been able to find directions for caring for the clinical thermometer after use.

Although the difference between a graduate, registered nurse and a practical nurse is carefully drawn, no mention is made anywhere of public health nurses, county nurses, visiting nurses, Red Cross nurses, hourly nurses (the omission of public health nurses seems inexcusable in a book especially intended for rural mothers). The helplessness of mothers in handling their first babies is graphically described, but no mention is made of the thousands of well-baby stations all over the United States where the mother can go to be taught to bathe the baby, or the graduate visiting nurses, also thousands in number, who could be called to teach the mother at home at a nominal fee. No mention is made of the increasing availability of mothers' milk, purchasable from large centers even at considerable distance these days. Directions are quite frequently incomplete, not to say confusing, and will leave the average mother in a daze, for example, "Baby should be trained to the vessel under a year of age" (p. 51) and not a word as to how to train, what position to hold the child in, nothing about the size of the potty, etc.

The book is evidently intended for the fairly well-to-do family since no substitutes for expensive equipment are suggested (again a sad lack if country mothers are remembered) and the chapter on "Common Practical Nursing Procedures" would have been much more valuable if a public health nurse had assisted in its writing. —D. D.

Those of us who were brought up on "Practical Nursing", Maxwell and Pope, will be glad to see this new edition "The Art and Principles of Nursing" by Amy Elizabeth Pope, R.N., and Virna M.

Young, R.N. (G. P. Putnam's Sons, New York, $2.75). Our old friends are all brought up to date—"Enemata," "Douches", "Counter Irritation" and fresh illustrations and new chapters enrich the volume.

The Council of Social Agencies, Washington, D. C., has compiled a budget book for families of low income. (Price 35c a copy plus 3c postage). While this book was prepared primarily for use in the District of Columbia and contains prices existing there, it is hoped that it will be of great value to agencies in other cities in planning the budgets of families on low income. A summary gives a minimum and maximum for a decent standard of living. Allowances for insurance, health, education and recreation are made.

A study made by the American Public Welfare Association has just been issued entitled *Medical Care of the Unemployed and their Families* under the plan of the Federal Emergency Relief Association. A limited number of copies are available without charge from the Association, 850 East 58th Street, Chicago, Ill. The data cover nursing activities very briefly.

McCall's Magazine has, in booklet form, a complete plan for a Community Christmas, in which everyone can play an important part. This plan has been thoroughly tested, and is both practical and simple. It is completely outlined in a booklet entitled "Christmas Giving," priced at 10c, and available from The Service Editor, McCall's, Dayton, Ohio.

Appleton-Century has prepared the "Tired Business Man's Library" composed of 15 brand new volumes of adventure and mystery fiction. It sells for $30 a set, $10 for a group of five, $2.00 per volume.

Correction: *Food Customs from Abroad* is published by the Massachusetts Department of Public Health and not by the Department of Public Welfare, as stated in October. The Department of Public Health also publishes the bulletin, *The Commonhealth.*

The *National Parent-Teacher Magazine* in a bigger and better format is the new title of the official organ of the National Congress of Parents and Teachers, formerly called *Child Welfare.* Subscription office, 1201 16th Street, Washington, D. C. One dollar a year.

FROM CURRENT PERIODICALS

Cough plate examinations for B. pertussis. Pearl Kendrick and Grace E derling. American Journal of Public Health, April, 1934. The technique of cough plate examinations for whooping cough and how the city of Grand Rapids made itself "whooping cough conscious" through its use.

Safety for the re-employed. Statistical Bulletin of the Metropolitan Insurance Company, February, 1934. "For every 10,000 persons re-employed, anywhere from one to more than fifty will be killed in the course of a year of emp'oyment."

Poliomyelitis. D. M. Meekison, M.D. June Supplement to the Bulletin of the British Columbia Board of Health (Vancouver). An address delivered to public health nurses at their refresher course at the University of British Columbia.

Doctor and nurse relationship. Clark H. Yeager, M.D. The Filipino Nurse (Manila, P. I.), July, 1934.

The behavior clinic in public health. C. B. Horton. Connecticut Health Bulletin (Hartford), July, 1934.

Modern trends in public health administration county health work. Joseph W. Mountin, M.D. American Journal of Public Health, July, 1934. Also a *New Deal in Health Education* by Bertrand Brown.

Tyranny at home. A Radio Dialogue. By Ruth O. McCarn and Lee Rabinowitz. Mental Health Bulletin, Illinois Society for Mental Hygiene (Chicago), for June, 1934.

Practical administrative policies for supervision of childhood-type tuberculosis. Based upon experience in Cattaraugus County. By John H. Korns, M.D. Milbank Memorial Fund Quarterly, July, 1934.

Milk-borne epidemic diseases in the United States and Canada, 1933. Report presented to the Conference of State and Provincial Health Authorities of North America. By S. J. Crumbine. Child Health Bulletin, July, 1934.

Changes in sanatorium procedure. By Lawrason Brown, M.D. Journal of the Outdoor Life, July, 1934.

Two Billion More. Margaret Culkin Banning. Saturday Evening Post, August 11th. A popular writer analyses the present relief situation.

A series of four articles on cancer. Mary Washburn Baldwin. The Baltimore and Ohio Magazine, Baltimore and Ohio Railroad (Baltimore), May through August, 1934.

For the first time, the National Advisory Council on Radio in Education enters the field of public health, with a series of broadcasts entitled "Doctors, Dollars, and Disease." There will be nineteen programs of fifteen minutes each (10:45-11:00 Eastern Standard Time), every Monday evening, from October 2nd through February 25th (excepting October 27, November 5, and November 12), over a nation-wide network of the Columbia Broadcasting System.

This series of broadcasts will consider the subject of medical economics, the cost of medical care, the relation between the medical profession and the public, and ways of reconciling the interests of the two groups. The purpose of this series of radio talks is not to advocate any one solution of the problem, but to furnish reliable information and stimulate discussion.

All the programs will be published by the University of Chicago Press, 5750 Ellis Avenue, Chicago, and each program will be available shortly after it is broadcast, for fifteen cents for individual numbers, or two dollars for the series of nineteen.

The Public Health Committee of the National Advisory Council on Radio in Education is headed by William Trufant Foster, Director of the Pollak Foundation, and includes Dr. Haven Emerson, Dr. Alice Hamilton, Dr. Thomas Parran, Jr., Dr. H. S. Cumming, and Dr. Ray Lyman Wilbur.

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Our English sisters are again ahead of us. The College of Nursing in London is offering two courses in industrial nursing—one a nine months' whole time course—36 guineas to college members and 45 to non-members, and a six months' part-time course—12 and 15 guineas respectively. (A guinea is 21 shillings, or about $5 in our money.)

In Canada the School of Nursing in coöperation with the Department of University Extension, University of Toronto, is offering a refresher course to public health nurses in industry. The enrollment is limited to forty. The course will consist of lectures, conferences, and observation visits, covering industrial hygiene, principles and practices in industrial nursing, and mental hygiene in industry. No credits will be given for the course. The fee is $3.

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Following is a list of the officers of the American Public Health Association for the year 1934-35:

President, E. L. Bishop, M.D., Nashville, Tennessee

President-Elect, Walter H. Brown, M.D., Palo Alto, California

Treasurer, Louis I. Dublin, Ph.D., New York City

Executive Secretary, Kendall Emerson, M.D., New York City

Chairman of Executive Board, Thomas Parran, Jr., M.D., Albany, New York.

Edward S. Godfrey, Jr., M.D., director of local health administration, New York State Department of Health, was elected to the Governing Council. Haven Emerson, M.D., and Clarence L. Scamman, M.D., both of New York City, and Huntington Williams, M.D., of Baltimore, Maryland, were elected members of the Executive Board.

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RECENT APPOINTMENTS

Ada Newman, State Director of Nursing, Nebraska.

Maud A. Tollefson, field advisory nurse, Wisconsin Bureau of Public Health Nursing.

Lydia Spoeneman, Educational Director, Visiting Nurse Association, Pittsburgh, Pa.

Lucile Gamble, Instructing Supervisor, Out-Patient Department, University Hospital, Ann Arbor, Mich.